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FISCAL YEAR 1990 BUDGET ISSUES RELATING TO MEDICARE PAYMENTS TO PHYSICIANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

APRIL 17, 1989

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FISCAL YEAR 1990 BUDGET ISSUES RELATING TO MEDICARE PAYMENTS TO PHYSICIANS

MONDAY, APRIL 17, 1989

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to call, at 1 p.m., in room B-318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
MONDAY, APRIL 3, 1989

PRESS RELEASE #10
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON FISCAL YEAR 1990 BUDGET ISSUES RELATING TO MEDICARE PAYMENTS TO PHYSICIANS

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee will hold a hearing on fiscal year 1990 budget issues relating to Medicare payments to physicians. The hearing will be held on Monday, April 17, 1989, beginning at 1:00 p.m., in B-318 Rayburn House Office Building.

In announcing the hearing, Chairman Stark said: "Medicare's system for paying for physicians' services must be reformed. Costs are increasing by an average of 15 percent a year. We can no longer afford to delay.

"This hearing, the second in a series, will give a number of major physician organizations an opportunity to comment on the recommendations of the Physician Payment Review Commission and the Part B proposals in President Bush's fiscal year 1990 budget."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND

The Physician Payment Review Commission has now agreed to recommend substantial revisions in the way Medicare pays physicians.

The Commission's recommendations, presented to the Subcommittee on Health at a hearing on March 21, 1989, include:

- A Medicare fee schedule based primarily on resource costs to rationalize the pattern of payments to physicians;
- The use of expenditure targets and increased research on effectiveness of medical services to control the growth in expenditures; and
- Limitations on extra-billing by physicians to limit out-of-pocket costs by the elderly and disabled.

President Bush's budget for fiscal year 1990 also includes a number of proposals to reduce payments to physicians. These proposals are not inconsistent with the fee schedule recommended by the Physician Payment Review Commission. The major Administration proposals include:

- A reduction of up to 12 percent in 12 procedures previously identified as overpriced;
- A reduction of eight percent in payment levels for radiology, anesthesiology and surgery services; and
- A limit on the increase in physicians' non-primary care services for fiscal years 1990 through 1992.

The Physician Payment Review Commission's proposals and the Administration's proposals would have different effects on physicians in the various specialties and geographic areas.

The Commission estimates that the Medicare fee schedule it recommends would increase allowed amounts for family practice by 40 percent and internal medicine by 18 percent, while reducing amounts for thoracic surgery by 19 percent, ophthalmology by 16 percent and radiology by 25 percent. Amounts allowed for physicians in metropolitan areas with a population over five million would decrease by 14 percent, while amounts for physicians in rural counties with populations of less than 25,000 would increase by 15 percent.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, April 28, 1989, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the office of the Subcommittee on Health, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman STARK. I apologize for the delay of calling the Health Subcommittee of the Ways and Means Committee to order to hear our second of three hearings on issues relating to the budget reconciliation and focusing on payment of physicians.

At our first hearing on March 21, Dr. Phil Lee, the chairman of the Physician Payment Review Commission, presented the commission's recommendations. These recommendations propose that we should do the following three things: First, adopt a new relative value scale based on the work of Dr. Hsiao and his colleagues at Harvard and I presume build a fee schedule based on that.

Second, protect the elderly and disabled from increased out-of-pocket costs by establishing limits on extra billing, and third, control costs by setting expenditure targets each year for total payments top physicians.

It was the Chair's understanding of these recommendations that none of them do much good by themselves and, in fact, if any of the witnesses today would testify to projects that would not include all three, the Chair would be most interested in how any proposal that doesn't encompass all of these three items makes good sense.

President Bush in his 1990 budget also proposed deficit reduction policies consistent with a resource based relative value scale. The Bush policies include a reduction of up to 12 percent in the fees for procedures identified as overpriced in 1987; an 8-percent reduction in fees for other radiological and anesthesiological and surgical services and a freeze on the MEI inflation update except for primary care services.

I might add again, and this is something that this committee has repeated and is concerned about, we do not as a committee nor does our staff seek out specific areas in the practice of medicine nor do we attempt to identify particular procedures for cost savings. These are brought to our attention by what we hope is, and will continue to be, people who objectively review these and have the professional competence to make those judgments based on existing statistical data and on the best objective scientific decisions that they could possibly come to.

At the March 21 hearing we heard from the American College of Surgeons and the American Medical Association. The ACS endorsed a gradual shift to the relative value scale and a phase-in of expenditure targets if—and I underline this—a separate spending category is established for surgical procedures. The AMA supported a new relative value scale-based fee schedule but opposed any limits on extra billing.

This afternoon, 11 medical specialty associations will discuss the proposed policies in greater detail. Their views are of special interest given the varying impact of a possible resource based relative value scale and physicians in different specialties and geographic locations.

Today's hearing is timely following Friday's announcement of an agreement between the President and the leaders of the House and Senate Budget Committees on a Federal budget for fiscal year 1990.

With a projected 14.6 percent increase in part B payments in fiscal year 1990, everyone agrees that physician payments will play a major role in this year's deficit reduction effort.

Reform of Medicare's physician payment system will not, of course, be easy. Few, if any, will be fully satisfied with the final product.

I am sure that the physician associations with us today understand both the importance and the difficulty of this project. I hope they will choose to work together with us, rather than simply opposing the entire task, in the weeks ahead.

We will hear support for the relative value scale from many of the specialists today. Some will suggest further study and some will already wish to make adjustments to it. It seems to me that the relative value scale is going to have to reach a consensus within the medical profession before this committee will be able to act.

As to extra billing, there is some support for limiting that and for mandatory assignment, there is one subspecialty group. As for expenditure targets, this list gets very short. One group might support it if the targets were separate and others suggest that they would support multiple targets if they are inevitable.

I might point out if every subspecialty had a target we would be right back where we started in negotiating yearly with each separate set of relative value scales. The Chair has tried to come to some kind of reasonable method of accommodating people with different interests both in the relative value scale and in the expenditure caps. It would be my hope that this committee would not have to be the referee in those decisions and someone like PhysPRC would be the court under which some specialties and subspecialties would plead their case.

My thought is that they would be far better to deal with the complexities of the level of physician care than is this committee. I look forward to the hearing. I would like to recognize our ranking member, Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman. I have very little to add except to underline the importance of the completion of the budget summit which will lay upon this subcommittee the responsibility of making recommendations for saving, and the word is in quotes, of $2.7 billion for the next fiscal year. It appears $1.8 billion of that would be reached under present laws. That leaves about $1 billion that has to come from some real pain and suffering as we suffer some changes in current law.

I think it is safe to say from here on we are going to need very specific recommendations from all our witnesses, not just what is wrong with the proposals before us but how you would suggest we go about achieving the savings which it appears we must do in order to continue our record of meeting the obligations put upon us by the budget process.

Thank you.

Chairman **Stark**. Thank you. Our first panel includes representatives of three major primary care organizations: Dr. Robert Graham, executive vice president of the American Academy of Family Physicians; Dr. Joseph Boyle, executive vice president of the American Society of Internal Medicine; Dr. James G. Nuckolls, president of the American Society of Internal Medicine; and Dr. Edwin Maynard, president of the American College of Physicians.

I will ask Dr. Graham to begin. I would state for the record and ask unanimous consent that all prepared testimony submitted today be included in the record in its entirety without objection and that we encourage our witnesses to expand on their prepared testimony or summarize it in any manner they are comfortable.

I am sure that we will bring out more details as the members of the committee inquire at the conclusion of the panel's prepared testimony.

Dr. Graham.

STATEMENT OF ROBERT GRAHAM, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. **Graham**. Mr. Chairman, we appreciate the opportunity to appear before you today.

We believe that the continued work of the Hsiao group at Harvard and the PhysPRC have provided this committee with a historic opportunity to rebase the payment for physician services under the Medicare Act to provide for more equitable and rational use of Federal resources.

The policy implications in the recommendations before you go far more broadly than simply the reform of physician payment. As you have heard within the last week in a related hearing, the possibility of differential payment for physicians has implications for manpower policy, access to services and quality of care.

Therefore, I think that as we focus perhaps on payment patterns and costs, we must keep in mind the possibility of any changes at this time as a more positive opportunity than simply in that narrow area. Our members, although they will be affected differently because their patterns of practice vary widely, are strongly behind the concept of a relative value schedule as a new basis for payment in Medicare.

They perceive that it is in their interest, certainly, but also perceive it is in the interests of their patients and their community.

Any proposals such as these will have controversy associated with them. The chairman has already alluded to several areas of controversy. We believe that it is the responsibility of an organization and the profession to comment on those areas as you look at policy options before you.

Let me comment on three of them: First, expenditure targets. I don't think anyone in the profession and probably no one in the Congress is comfortable with the concept of expenditure targets because it makes explicit something which has heretofore been implicit, and that is the very real possibility that we do not have adequate resources to do everything we might wish for all beneficiaries at all times.

We have had implicit expenditure targets for at least the last 15 years. No one knows that more than office-based primary care physicians such as family physicians and general internists. The suggestion before you is that there should be expenditure targets which try to limit or set constraints on the total expenditures under Medicare serviced.

Our comment to you is that if indeed it is the judgment of the committee that we need to move from implicit to explicit in recognizing a limitation of resources and if the concern is on high volume and high cost services, then a single expenditure target does not have the outcome that you seek and indeed may be the reverse.

The growth in volume of office visits in the last 15 years has been nil. The increase has been in the category of services which can be defined. It would be our suggestion that if there needs to be targets, they should be disaggregated and need to be clearly focused on the services where you believe the volume or cost is greatest.

Would this lead to a circumstance where there might be 6 or 16 categories? Perhaps, but we believe it does have to be disaggregated if you do not want a perverse outcome.

Second, beneficiary protection, what happens to those beneficiaries as payments follow new billing practices? We believe it is reasonable to suggest that some protection be made for those beneficiaries who have the least resources. We propose in the implementation of the fee schedule that individual Medicare beneficiaries at two times the poverty level or below would have physicians agree to accept what is now called mandated assignment.

For other mandated beneficiaries there would be the potential based on the physician's judgment and knowledge of the patient's financial status to base the billing 25 percent higher than the fee.

Third, the areas of geographic differentials, although PhysPRC has made a recommendation which we believe is an improvement over current policy, we don't believe there is documentation to base the continuation of the geographical differential. We believe that should be closely reexamined and there should be no geographical differential under relative value scale.

Mr. Chairman, we believe there is a very great need for the PhysPRC to continue the type of work it has done. We believe they can and should provide technical advice in the transition. They should provide and support to the development of clinical practice guidelines and most importantly they should serve as the focal point for the different views of the medical profession in terms of what is the soundest public policy under Medicare.

The chairman has expressed himself several times of the feeling that it would be desirable for the medical profession itself to resolve these issues.

So long as the Federal Trade Commission continues in its view of its responsibilities, the ability of physician associations or hospitals to work constructively together to set limits or targets is prohibited. So I believe we must continue to work with PhysPRC and this committee.

Let me close by saying that we believe that the opportunities before you for implementation in a timely and immediate fashion of the relative value schedule is an opportunity that this committee should take and we look forward to working with you in that goal.

[The statement of Robert Graham, M.D., follows:]

STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

I am Robert Graham, M.D., Executive Vice President of the American Academy of Family Physicians, the national medical specialty organization representing over 65,000 practicing family physicians, residents in training and medical students. On behalf of our members and their patients, I am delighted to again appear before this subcommittee to discuss with you Medicare physician payment reform with a fee schedule based on resource costs.

The members of this subcommittee are well aware of and sensitive to the problems in the current Medicare system. The "CPR" payment methodology is widely acknowledged to be highly inflationary, complex, unpredictable, inequitable, and fraught with perverse financial incentives. Medicare expenditures have experienced unrelenting growth, yet access to many important services remains a problem.

I have appeared before you on several occasions to state the many concerns of the American Academy of Family Physicians with the Medicare system. We have shared with you the difficulties experienced by communities with limited access to primary care services and by family physicians discouraged by an inequitable reimbursement system that undervalues many important medical services. Just last week at a hearing of your subcommittee the current Medicare reimbursement system was targeted as a major contributor to geographic and specialty maldistribution. Several witnesses highlighted reimbursement inadequacies and inequities as the primary disincentive to entering the specialty of family practice. Today I appear before you to encourage you to enact a solution to many of these problems using the Harvard resource-based relative value scale (RBRVS) as the cornerstone of that solution.

RESOURCE BASED FEE SCHEDULE:

The American Academy of Family Physicians believes that a Medicare physician fee schedule based on the Harvard RBRVS offers greater potential to achieve meaningful physician reimbursement reform than anything that has been proposed in many years. We believe that such reform will benefit our patients by restoring a proper emphasis on primary care and encouraging the provision of disease prevention and health promotion services. Furthermore, we project that badly needed long-term improvements in access to primary care and prevention services will result from encouraging physicians to enter primary care specialties.

By estimating the resource costs of providing physician services, the RBRVS provides an approximation of the relative prices that would be achieved if it were possible to deliver physician services in a competitive market. In achieving this result we believe the RBRVS provides a framework for grounding Medicare physician payment squarely in the American economic tradition.

The Harvard RBRVS study has now been thoroughly reviewed by health services researchers, economists, and representatives of beneficiary groups, government, business and labor, and medicine. For the most part the study's results have been judged valid and reliable. Some methodological shortcomings have been identified and are being addressed by the Harvard team and/or PPRC in a timely manner. We specifically congratulate PPRC for its excellent work to refine the fee schedule, and to develop reasonable approaches to policy issues surrounding implementation of a Medicare fee schedule. In particular, we are pleased with PPRC's conclusion that "when a service provided by physicians in different specialties is essentially the same, the payment should be the same." Furthermore, the Academy supports incorporation of time into the description of visit codes, to promote more accurate use of codes for these evaluation and management services. We believe that a resource-based Medicare fee schedule as developed by Dr. Hsiao and his team and as modified by PPRC is sufficiently developed to allow Congress to move in an expeditious manner to reform Medicare physician payment.

The results of the RBRVS study suggest that current payments for many physician services are severely out of balance in relation to the resource costs of providing those services. A resource-based fee schedule would revaluate physician services in a manner favorable to primary care and rural areas. The redistributive impact of adopting a resource-based fee schedule would be consistent with previous Congressional actions providing higher MEI updates for primary care services and underserved areas, placing floors under the prevailing charges for primary care services, and selectively cutting the prevailing fees of some high-volume, overpriced procedures.

As the Subcommittee heard at its recent hearing on graduate medical education, there is a significant and persistent shortfall in the supply of primary care and rural physicians relative to the need for their services. The United States has a smaller proportion of primary care physicians than any other developed country (13 percent of U.S. physicians are family physicians as compared to 53 percent general/family physicians in Canada). Inadequate reimbursement has proved to be a major disincentive for physicians to choose these types of practice and has resulted in severe access problems for some Medicare beneficiaries. By correcting the existing inequities in Medicare physician payment, an RBRVS-based fee schedule will, in the long run, encourage more physicians to choose primary care specialties and rural practice locations.

Recent PPRC simulations of the redistributive impact of a resource-based fee schedule suggest that the Medicare income of family physicians will on average increase by 30 to 40 percent. This is considerably less than the 65 to 70 percent increase projected by the Harvard team last Fall. It is important to recognize that, on average, approximately 10 percent of family physicians' income is derived from the Medicare program. Furthermore, family physicians typically provide a broad range of services, some of which will undergo a fee reduction under a resource-based fee schedule.

Geographic Multiplier

The PPRC recommends that the Medicare fee schedule by modified with a geographic multiplier that is intended to reflect geographic differences in the cost of practice. While we recognize that PPRC's recommendation for a geographic multiplier would eliminate much of the existing geographic differential in Medicare prevailing-charge screens, it is our position that there should be no differentiation in physician fees based on practice location. This payment policy is grounded in the belief that equivalent service should result in equivalent compensation.

The urban/rural differential in current Medicare prevailing fees has compromised beneficiaries' access to medical care. Lower fees have discouraged physicians from locating and maintaining their practices in rural areas. Furthermore, low approved charges affect physicians' willingness to accept assignment for Medicare claims and result in higher relative out-of-pocket expenses for rural beneficiaries.

Imposing a geographic multiplier on a Medicare fee schedule lacks merit on three counts. First, it is inconsistent with federal policies that incorporate uniform national rates, such as federal income tax, social security payments, and the Medicare Part B premiums. Second, no systematic, significant, and reliable differences in the cost of urban and rural practices have been demonstrated. The cost-of-practice index proposed by PPRC is based on proxy measures of the prices faced by physicians in running their practices and yields results that are in marked contrast to surveys that have directly measured physicians' costs of practice. Furthermore, the index incorrectly assumes that the costs of medical equipment, repairs, and transportation do not vary geographically, and it fails to consider the unavoidable necessity of maintaining a larger standby capacity in rural practices. Third, there are non-quantifiable cost of rural practice, such as being on call virtually at all times, that obviate any rationale for higher reimbursement rates in urban areas.

Congress would be well advised to approach the creation of a geographic multiplier with caution. The consequences of having made ungrounded assumptions about geographic differences in the costs facing hospitals certainly are not lost on this committee. Because of its redistributive impact, the political cost of attempting to undo a geographic multiplier for physician services could be substantial.

Updating the fee schedule

The Academy believes that the Physician Payment Review Commission will continue to have an important role under a reimbursement system with a resource-based fee schedule. Specifically, the Academy recommends that PPRC have a defined role in working with the American Medical Association and individual medical specialty societies in annually updating the Medicare fee schedule. The process should include frequent and regular monitoring of practice costs, and updating to reflect changes in practice costs which are anticipated because of potential changes in Medicare reimbursement for some services.

FINANCIAL PROTECTION OF MEDICARE BENEFICIARIES:

Family physicians understand the financial burden that health care can place on Medicare beneficiaries. Patients make known their fears about rising health care costs and share their uncertainty about Medicare payment policies. The Academy believes that any new Medicare reimbursement system should be fair to beneficiaries.

Simulations by the Physician Payment Review Commission suggest that, on average, out-of-pocket expenses for beneficiaries will decrease under a resource-based Medicare physician fee schedule. However, hidden in these highly aggregated averages is the potential for some beneficiaries to experience significantly increased expenses. For this reason the Academy supports measures to protect beneficiaries both during the transition to and after the implementation of a fee schedule.

During the proposed transition to a fee schedule we anticipate that prevailing charges will move toward the projected fee schedule amounts. As these modifications are made, it is imperative that Medicare beneficiaires be protected from excessive balance billing for those services for which the fee is reduced. This can be accomplished by limiting the total amount which physicians can charge to a specific percentage of the prevailing charge, such as 125 percent. This strategy has been utilized by Congress in implementing limits on "over priced" services and therefore would be consistent with current policy.

The Academy supports two strategies for protecting beneficiaries after the fee schedule is in place. This first proposal is aimed at protecting the most financially vulnerable elderly. Assignment should be required for all services provided to Medicare beneficiaries whose income is below two times the poverty level. This proposal goes somewhat beyond the PPRC proposal that calls for assignment for services provided to "qualified Medicare beneficiaries" covered by Medicaid.

The second strategy is to limit balance billing by all physicians for all services to Medicare beneficiaries not covered by the above proposal to 125 percent of the fee schedule amount. These limits would replace the current Maximum Allowable Actual Charge (MAAC) limits. The Academy believes that limiting balance billing to 125 percent of the fee schedule is an equitable balance of the interests of beneficiaries and physicians.

For reasons noted in our comments below on expenditure targets, the Academy's support of these beneficiary protection provisions is contingent on the understanding that there will be annual aggregate fee schedule updates which fully account for legitimate increases in the cost of practice, increased number of beneficiaries, the aging of that population and technological advances. The balance of interests must continue to be equitable for the program to remain viable.

EXPENDITURE TARGETS:

The Physician Payment Review Commission has recommended utilizing expenditure targets as an integral part of an overall strategy for moderating the growth in volume of physician services through a reduction in unnecessary and inappropriate services. The AAFP believes that the Medicare fee schedule may help reduce inappropriate increases in the volume of services by correcting incentives for overuse in the current payment system. We understand, however, that a fee schedule alone may not fully address these problems.

The Academy believes that a decision to utilize expenditure targets as a means of moderating increases in Part B expenditures represents an explicit decision to ration services to Medicare beneficiaries. It is a change from the perception of current policy, which is that unlimited resources are available to meet beneficiaries' needs.

An expenditure target that caps physician expenditures in the aggregate would not automatically distinguish between limits on effective or ineffective services nor between appropriate or inappropriate services. We have concern therefore, that an expenditure target scheme unless targeted to specific classes or categories of "overused or overpriced" services could have the untoward effect of markedly decreasing access to basic, day to day services.

A recent examination of Medicare claims data for calendar years 1983 through 1986 demonstrates a very uneven pattern of growth in the volume of services. While the per beneficiary volume of primary care services (such as office visits) has increased little, if at all, volume has increased rapidly for surgical and diagnostic procedures. Three kinds of service grew at above average rates: surgery, radiology, and specialized diagnostic tests such as electrocardiograms, cardiac stress tests, and echocardiography. Together these three types of service account for two-thirds of the increased spending. In sharp contrast to the increases in surgery, radiology, anad diagnostic tests, total number of office and hospital visits per beneficiary changed very little. If Congress decides that the only feasible way to control costs is through expenditure targets, the Academy proposes that the targets be implemented in an way that minimizes the impact on access to primary care services, by ensuring the appropriate distribution of limited resources. Further, if congress believes that it should proceed with this strategy, the Academy would propose that separate expenditure targets should be established for specific services or categories of services that have a high cost and high volume profile and for which there is a large element of physician discretion.

There continues to be a need for improved beneficiary access to primary care services. Congress in previous years has recognized the need and has taken specific action to encourage provision of these services (higher MEI updates for primary care servies and for underserved areas, and a floor under the prevailing charges for primary care services). Conversely, Congress has adopted cuts in the prevailing fees for some high-volume, over-priced procedures. We believe that Congress should once again look at the public policy objectives of improving access to primary care services and take this into account when considering an expenditure target approach to limit Medicare spending.

We are concerned that present liability climate could undo the intended effect of various efforts to reduce the volume of minimally benefical services. Under the existing civil justice system, if a patient is harmed as a result of withholding a service that has any probability of benefit, no mater how small, it is difficult to defend that decision in court. The fear of incurring a liability action and the incentives posed by expenditure targets influence decisions about rendering servics of minimal potential benefit in opposite directions. The proposal advanced at an earlier hearing of this subcommittee to remove beneficiaries from the traditional system for resolving medical liability disputes by requiring some type of arbitration is worthy of further study and should be given serious consideration.

While expenditure targets provide a financial incentive for reducing volume, they do not automatically provide a mechanism to decrease inappropriate and unnecessary services. It is unclear at this time how the medical profession can collectively control utilization in order to meet the targets. At this point there are serious questions about how an expenditure target approach would be implemented and its impact on the health care system. In no case should expenditure targets be applied until the resource-based Medicare fee schedule is fully in place. The effects of the targets could then be carefully monitored.

During the transition to the fee schedule, practice guidelines should be developed and made available to the medical community to assist in identification of unnecessary and inappropriate services. The Academy is highly supportive of effectiveness research and believes that this information can assist physicians in this increasingly complex medical climate to understand the most efficacious ways to practice medicine. The Academy already is working to establish clinical policies for family practice in concert with Dr. David Eddy at Duke University. We believe that practicing physicians will be able to use this information to provide optimal medical care to their patients.

SUMMARY:

The message that I would wish to leave with you today is a positive one, one of hope. Congress is presented with a unique opportunity to enact meaningful reform of Medicare physician payment this year. The excellent work of Dr. Hsiao and his team and of the Physician Payment Review Commission provide a firm base on which to rationally restructure Medicare. A resource-based fee schedule would create a level playing field for physicians, provide for a health care system that is more balanced in terms of the specialty and geographic distribution of physicians, moderate the growth in Medicare expenditures, and, most importantly, ensure much improved access of beneficiaries to appropriate medical services. The American Academy of Family Physicians urges you to enact Medicare physician payment reform this year.

Chairman **Stark**. Thank you.

Rarely do I interject in the middle of a panel. You raised one point and I think for all the witnesses at the table and those in the room, the idea of relating payment limits to the beneficiary's income is something that is not abhorrent to this committee. We have wrestled with it in previous years in developing the Medicare Catastrophic Coverage Act.

There is, however, almost an absolute prohibition in that the only income figures that are generally available in the United States are those that the Internal Revenue Service has. The other hat that this committee wears often as a matter of tax policy is perhaps that the rights of policy do not make that information available to others.

It is a problem for us as well as many of you who rightly say there should be some relationship between ability to pay. It is the hardest problem we have to deal with. The catastrophic bill Mr. Gradison wrote has us wrestling with that problem. I merely interject there to say it is a problem, and that the solution you present has a great deal of possibility with the committee, but the practicality of ever accomplishing that is very problematic for us.

Dr. **Graham**. We understand that. The recommendation is made with the feeling that technical problems can be addressed, but the major concept we want to lay out is that we believe that is the direction in which we should go.

If there is a better formula or ceiling or floor, that is where the discussion should focus.

Chairman **Stark**. I think you will find very little objection to that on the committee.

Dr. Boyle.

STATEMENT OF JOSEPH F. BOYLE, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE, ACCOMPANIED BY JAMES G. NUCKOLLS, M.D., PRESIDENT

Dr. **Boyle**. Thank you, Mr. Chairman.

I am Joseph Boyle, M.D. I am the executive vice president of the American Society of Internal Medicine. With me today is Dr. James Nuckolls, the society's president.

The American Society of Internal Medicine [ASIM], representing physicians nationwide who specialize in internal medicine, believes that 1989 is the year that Congress should move forward on putting in place a comprehensive plan to reform the Medicare payment system.

ASIM believes that an effective plan for payment reform should consist of:

First, implementation of a fee schedule based on a resource based relative value scale [RBRVS].

ASIM specifically supports the PhysPRC's recommendation to enact legislation this year to mandate a Medicare fee schedule based on an RBRVS being completed by Harvard University, with partial implementation taking place within 6 months of enactment, and full implementation over 2 years.

Second, establishment of a safety net to protect low-income beneficiaries from out-of-pocket expenses that they cannot afford.

Although ASIM believes that beneficiaries are best served by a policy that enables them to contract with physicians who may bring to their care more experience, training, or expertise than the norm—and who therefore charge an appropriately higher fee than that allowed by a fee schedule—it is appropriate to provide special protection for low-income beneficiaries. Consequently, ASIM supports appropriate limits on balance billing to low-income beneficiaries. The PhysPRC's proposal to require acceptance of assignment for all individuals whose Medicare cost-sharing must, by law, be paid by their respective States is consistent with this principle. In parenthesis I also believe there are technical ways in which this can be accomplished and we will be happy to make some suggestions to you.

Third, expansion of policy is designed to develop the scientific knowledge and the means to assure that only effective services are reimbursed by the Medicare Program. ASIM has previously provided Congress with 14 specific recommendations on the volume issue. They include increasing medical review for services provided in an organized outpatient setting, substantially increasing the resources devoted toward developing practice guidelines, particularly for high volume procedures; studying ways to bundle certain physician services; increasing data collection and analysis; and instituting measures to improve the effectiveness of medical review. We urge Congress, however, to proceed cautiously before mandating measures that could diminish access and quality of care, such as the PhysPRC's recommendation for national expenditure targets.

Fourth, enactment of interim measures for fiscal year 1990 that are consistent with long-term reform based on RBRVS.

Capping prevailing charges for radiological, anesthesia, and surgical [RAS] services after adjustment for cost of practice, at some percentile above the national mean—for example, 120th percentile—and increasing the existing floor—now set the 50th percentile of the national mean—for primary care services, could achieve fiscal year 1990 savings in a way that is consistent with long-term reform based on the RBRVS. It would also be far more fair than the across-the-board cuts in those services proposed in the President's budget.

ASIM believes that this comprehensive approach to payment reform will have a favorable impact on several objectives that should be driving long-term reform.

By substantially improving payments for undervalued primary care services, particularly in rural communities, payment reform with an RBRVS fee schedule at its core will correct distortions that now act as a barrier to provision of these services in underserved areas. Physicians will no longer be discouraged by the payment system from entering primary care services or practicing in rural areas.

An RBRVS fee schedule, by neutralizing incentives that favor one type of care over another, will also enhance quality. For the first time, physicians will not be biased by higher payments for the work involved for some services compared to others in making decisions on how to best treat their patients. Since the amount of time a physician spends with patients correlates closely with quality of care and patient satisfaction, the RBRVS—by no longer penalizing physicians for time-consuming cognitive services—will also enhance the overall quality of physician-patient encounters.

Establishing limits on balance billing to low-income beneficiaries will protect those who cannot afford to pay more than the Medicare-approved amount under a fee schedule, while maintaining the basic right of beneficiaries to choose and contract with any physician of their choice. RBRVS-based reform will also improve overall acceptance of assignment, particularly for undervalued evaluation and management services, and reduce patients' coinsurance for surgery.

The impact on the budget of future increases in payment rates will also be far more predictable than under the existing customary, prevailing and reasonable charge system. By tying future increases to a reasonable measure of inflation, such increases will not exceed that which is necessary to maintain the same level of service to beneficiaries. In addition, by neutralizing incentives that may encourage excessive reliance on certain technological services, overall costs can be expected to moderate in the long run. Development of practice guidelines can also achieve future cost savings, particularly if developed first for those services that have experienced the greatest increase in volume.

Mr. Chairman, ASIM strongly believes that Congress should move immediately on developing a legislative package that would incorporate these recommendations for long-term reform of the payment system. Implementation of an RBRVS fee schedule beginning in 1990 is at the core of this proposal, and therefore merits immediate action and attention by Congress. ASIM stands ready to assist the subcommittee in any way possible in bringing this proposal to fruition.

Chairman STARK. Thank you.

[The statement of Joseph F. Boyle, M.D., follows:]

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

INTRODUCTION

My name is Joseph F. Boyle, MD, Executive Vice President of the American Society of Internal Medicine (ASIM). I appreciate the opportunity to express the views of internists and internists-subspecialists nationwide on reform of the Medicare system of payment for physician services, with particular attention to the proposals just released by the Physician Payment Review Commission (PPRC).

ASIM strongly believes that Congress should act this year in putting in place a comprehensive approach to reforming the Medicare payment system. For at least the past eight years, Congress and the administration have directed most of their attention toward identifying immediate ways to reduce Medicare Part B expenditures, rather than formulating a comprehensive, long-term plan for reform. Now that the PPRC has fulfilled its charge to develop recommendations to Congress on payment reform, there no longer is a reason for this country to delay any further in deciding how it wishes to reform the Medicare payment system. ASIM urges this committee not to allow attention to 1990 deficit reduction to result in further delay in taking up the issue of long-term reform. Every year that goes by without Congress taking up long-term reform is a year of lost opportunity to correct distortions in the existing system that adversely affect the accessibility, quality, and cost of physician services.

ELEMENTS OF COMPREHENSIVE REFORM

ASIM believes that an effective, comprehensive, and long-term approach for payment reform should consist of the following elements:

1. **Implementation of a fee schedule based on the Harvard resource based relative value scale (RBRVS), as called for by the Physician Payment Review Commission.**

The PPRC has called on Congress to enact legislation this year to mandate a Medicare fee schedule based on the RBRVS being completed by Harvard University, with partial implementation taking place within six months of enactment, and full implementation over two years. Geographic differentials in payment would be limited to differences in the costs of providing services. The RBRVS would for the first time link Medicare payments with the work or resources (time, mental and physical effort, judgment, and overhead) required to provide physician services.

ASIM is particularly pleased that the PPRC, following an extensive review of the methodology and raw data collected in the Harvard study, consultation with outside experts, and testimony by numerous physician organizations, has concluded that the basic methodology of the Harvard RBRVS is sound. Further, ASIM agrees with the Commission that the estimates of physician time and effort developed by Harvard should be used as the initial basis for that component of the RBRVS in a new Medicare fee schedule. Although the PPRC has identified areas where it and Harvard are undertaking further refinements, it is extremely significant that the Commission has rejected the views of those who argue that the RBRVS is inherently "flawed", or that sufficient refinements cannot be made within the next several months in order to permit implementation as early as April, 1990.

It is also important to recognize that the Harvard RBRVS, and the recommendations of the Commission, reflect Congress' own interest in establishing a more rational basis for determining physician payments that based on the resource costs of providing those services. Both the Omnibus Budget Reconciliation Acts of 1985 and 1986, which mandated the development of an RVS based on resource costs, expressed this desire. Congress should now move forward and enact legislation, as recommended by the PPRC, to mandate that implementation of a fee schedule based on the RBRVS begin in April 1990, with full implementation taking place within two years.

The Commission is also recommending that the Medicare fee schedule determine payments to all physicians, including those already paid under separate fee schedules. ASIM strongly supports this recommendation. As the Committee is aware, OBRA 1987 mandated implementation of separate fee schedules for anesthesia services and the services provided by radiologists, and called on the Secretary of HHS to develop a proposal for a fee schedule for pathology. ASIM strongly agrees with the PPRC that these efforts should be incorporated into a uniform RBRVS fee schedule for all physician services.

ASIM strongly believes that it would be inconsistent with the PPRC's recommendation for Congress to require establishment of additional separate fee schedules for subsets of physician services, such as surgical procedures. As this committee is aware, the

American College of Surgeons (ACS) has proposed a separate fee schedule for surgery only. Under this proposal, the surgical fee schedule would be established at a budget neutral level. This proposal ignores one of the major advantages of establishing a uniform fee schedule based on the Harvard RBRVS: the ability to make comparisons on the relative work of physicians both between and within specialties. Without being able to make such comparisons, it is impossible to correct distortions in the existing pricing system that now favor technological procedures over evaluation and management services. Simply reallocating resources within surgery by partial use of resource costs would in no way correct the disparity in reimbursement between physicians' evaluation and management (or cognitive) services and technological procedures.

Moreover, a budget neutral target for surgical services would preclude any increase for evaluation and management services, thus eliminating the advantages that would accrue to the medical care system from improved reimbursement for those historically undervalued services. Separate fee schedules are also far more confusing and complex to administer than a uniform, inclusive RBRVS fee schedule that applies the same rules of payment to all services by all physicians, regardless of specialty. We believe that whatever Congress decides should be done with the physician payment system, all physicians, in all specialties, should be wiling to play by the same rules.

On other issues relating to the Commission's recommendations on an RBRVS fee schedule, ASIM:

- Supports incorporating average time descriptors in CPT-4 codes for visit services. ASIM agrees with the PPRC's conclusion that this approach will be far more effective in eliminating potential miscoding of services than "collapsing" CPT-4 visit codes. Consequently, we urge Congress to act favorably on the Commission's recommendation to delay the OBRA 87 mandate to HHS to "collapse" such codes.

- Supports establishing the initial dollar conversion factor at a budget neutral level.

- Supports limiting variations in payment levels by region only to actual differences in the cost of providing services (overhead). As discussed later, this will significantly improve access to physician services in underserved rural and inner city communities.

2. **Establishment of a "safety net" to protect low-income beneficiaries from out-of-pocket expenses that they cannot afford.**

Although ASIM believes that beneficiaries are best served by a policy that enables them to contract with physicians who may bring to their care more experience, training, or expertise than the norm--and who therefore charge an appropriately higher fee than that allowed by a fee schedule--it is appropriate to provide special protection for low-income beneficiaries. Consequently, as part of comprehensive reform of physician payment, ASIM supports appropriate limits on balance billing to low-income beneficiaries. The PPRC's proposal to require acceptance of assignment for all individuals whose Medicare cost-sharing must, by law, be paid by their respective states (i.e., all those whose incomes are below the U.S. poverty level) is consistent with this principle.

ASIM strongly believes, however, that it is inappropriate and unnecessary to establish an overall limit on charges to all beneficiaries at some percentile level above the payment levels established by the fee schedule, as the Commission has recommended. Such a requirement, in ASIM's view, is a prescription for mediocrity. It is well recognized that in every field--including engineering, law, architecture and accounting--there are some individuals that have more experience, greater expertise, and offer a better service than the norm for their field. Those individuals typically and appropriately charge more for their services than the average. This is as true in medicine as it is in any other field of endeavor. Patients should have the right to select physicians who bring greater skill to treating their individual problems, and who therefore have an appropriately higher charge. Limiting all physician fees to some pre-determined percentile above the RBRVS fee schedule would preclude that choice. It would also act as an discentive for physicians to obtain additional skills and training, since there would be no additional compensation to recoup the cost of such training. Any fee schedule, even one based on resource costs, by its nature represents a standard or average; balance billing is the only way to recognize differences in the skill and training of individual physicians, and in the needs and desires of individual patients.

3. **Expansion of policies designed to develop the scientific knowledge—and the**

means—to assure that only effective services are reimbursed by the Medicare program.

ASIM has previously provided Congress with a paper titled "Controlling the Volume of Ineffective Medical Services: A Plan of Action" that included 14 specific recommendations on the volume issue. The recommendations include increasing medical review of services provided in organized outpatient settings; substantially increasing the resources devoted toward developing practice guidelines, particularly for high volume procedures; studying ways to bundle certain physician services; increasing data collection and analysis; and instituting measures to improve the effectiveness of medical review. ASIM strongly supports the PPRC's proposals for a significant expansion of funding for effectiveness research and the development of practice guidelines.

We urge Congress, however, to proceed cautiously before mandating measures that could diminish access and quality of care, such as the PPRC's recommendation for national expenditure targets. ASIM agrees with the Honorable Henry Waxman, chairman, Subcommittee on Health, Energy and Commerce Committee, who recently stated in testimony before the House Budget Committee that "We must proceed cautiously in seeking to reduce the growth in the volume . . . of services furnished under Medicare. The best strategy, in my view, is to invest some money where it will contribute to a better understanding of the effectiveness of services and better tools for eliminating inappropriate care."

Unlike the Commission's recommendation on the RBRVS fee schedule, which reflects over ten years of debate and evaluation, and two and one-half years of intensive work on the part of the PPRC, the expenditure target proposal has not undergone critical scrutiny. This concept has not been the primary focus of the Commission's hearings and work over the past several years. Consequently, the Commission has not had the benefit of the same type and degree of expert advice, public comment, and research that were reflected in its recommendation on the RBRVS fee schedule. This is unfortunate, particularly given the fact that the expenditure target approach could have even greater ramifications for the quality and accessibility of medical care in this country than a fee schedule.

The purpose of the expenditure target approach is to limit services provided to Medicare beneficiaries. As such, it must be recognized as a form of rationing. According to the dictionary, "ration" means to restrict to limited amounts. The Commission acknowledged in its March 1988 report to Congress that "the intent of expenditure targets is to make explicit to physicians the limits of the resources society has decided to make available for health care..."

Presumably, the Commission intends for only "unnecessary" or "ineffective" services to be eliminated. Given the lack of data and consensus on the effectiveness of different medical services and procedures--and the inherent contradiction in attempting to set a limit on overall expenditures without any public consensus of how much *should* be spent on medical care--it takes a large and unjustified leap of faith to presume that only "waste" will be cut from the system.

Put into individual terms, expenditure targets can only work if individual doctors decline to provide certain services to their patients that they otherwise would have provided. *Without a scientific basis for making such a determination, however, it is just as likely that "effective" as "ineffective" services will be denied, particularly in grey areas where there is no clear consensus on what is the best way of treating a particular problem.* Consequently, it is the patient, not the physician, that is at risk under the expenditure target concept. This distorts the physician's traditional role as advocate of his or her patient, by placing the physician in the position of limiting services to patients in order to meet predetermined targets established by the federal government.

It is also unclear how the medical profession can collectively control utilization across the country in order to meet the expenditure target. An individual physician who practices a conservative style of medicine would still be financially penalized if overall expenditures exceed the expenditure target limit. Similarly, lower cost regions of the country will be at risk for higher utilization in other parts of the nation. Physicians in one specialty will similarly be at risk if physicians in other specialties increase their volume of services. Consequently, expenditure targets place individual physicians at risk for behavior by their colleagues that is outside their own control. Moreover, there is no organized system of utilization review now in place nationwide that would enable the profession to collectively control the volume of services.

What is needed instead is the development of the data and scientific basis needed to establish guidelines for evaluating the effectiveness of different medical and surgical interventions. A strategy designed to obtain the knowledge--and the means--for reviewing and evaluating the effectiveness of different ways of treating patients offers far more potential than expenditure targets for appropriately controlling the volume of ineffective medical services, without compromising patient care. By developing guidelines first for high volume procedures where it may be relatively easier to obtain a consensus on effectiveness, it is likely that the Medicare program can begin saving significant amounts of money in the relatively near future -- without resorting to the imposition of expenditure targets. ASIM commends Representatives Stark and Gradison for introducing the Patient Outcomes Research Bill, which will greatly expand federal support for activities to develop and disseminate such guidelines. Such an approach should be given a chance to work before Congress concludes expenditure targets are necessary or desirable.

4. **Enactment of interim measures for FY 1990 that are consistent with long-term reform based on RBRVS.**

ASIM recognizes that Congress has an immediate interest in moderating Part B expenditures as part of FY 1990 deficit reduction. Consequently, we would support appropriate measures to reduce spending, provided that they are fair, reasonable, and not in conflict with the objectives of long-term reform. Capping prevailing charges for radiological, anesthesia, and surgical (RAS) services, after adjustment for cost of practice, at some percentile above the national mean (e.g. 120th percentile), and increasing the existing floor (now set at the 50th percentile of the national mean) for primary care services, could achieve FY 1990 savings in a way that is consistent with long-term reform based on the RBRVS. It would also be far more fair than the across-the-board cuts in RAS services proposed in the President's budget, since it would reduce payment for RAS services only in those areas that are now reimbursed well in excess of what can be explained or justified simply on the basis of higher practice costs.

According to PPRC, an RBRVS fee schedule with geographic multipliers based on cost of practice would in general decrease reimbursement for RAS services provided in large metropolitan areas, and increase payments for primary care services in smaller metropolitan and rural areas. Establishing a cap on prevailings for RAS services, and increasing the floor on prevailings for primary care, would therefore simulate the effects of the RBRVS by targeting those services that are most likely to be increased or decreased once the fee schedule is implemented. Preliminary estimates by CBO and PPRC on variations of this proposal (e.g., capping prevailing charges for all Part B physician services and raising the floor for primary care only) suggest that such an approach might bring about substantial FY 1990 savings, although the specific option of capping only charges for RAS services has not yet been assessed. ASIM also believes that primary care services not subject to the new floor on prevailing charges should receive the full Medicare economic index (MEI) update.

ASIM cautions Congress, however, to consider the magnitude of cuts that have already taken place in Medicare Part B before deciding on the extent of further cuts. In addition, ASIM strongly believes that no portion of Medicare should be considered to be off-limits, and that Congress should consider appropriate increases in revenue--such as an increase in so-called "sin" taxes--in its efforts to achieve deficit reduction.

IMPACT ON ACCESS, QUALITY, OUT-OF-POCKET EXPENSES, COSTS, AND VOLUME

ASIM believes that this comprehensive approach to payment reform will have a favorable impact on several objectives that Congress, the medical profession, the Physician Payment Review Commission, and others agree should be driving long-term reform.

Improving Access and Quality

By substantially improving payments for undervalued primary care services, particularly in rural communities, payment reform with an RBRVS fee schedule at its core will correct distortions that now act as a barrier to provision of these services in underserved areas. The interim measures proposed above (capping prevailing charges for RAS services and raising the floor on payments for primary care) will also help move the system in the appropriate direction.

An RBRVS fee schedule, by neutralizing incentives that favor one type of care over another, will also enhance quality. For the first time, physicians will not be biased by higher payments for the work involved for some services compared to others in making decisions on how to best treat their patients. Consequently, this plan represents an important step in assuring that physicians' decisions are based solely on what is best for their patients, rather than on which services are more financially rewarding for the work involved. Since the amount of time a physician spends with patients correlates closely with quality of care and patient satisfaction, the RBRVS--by no longer penalizing physicians for time-consuming cognitive services--will also enhance the overall quality of physician-patient encounters.

Protecting Beneficiaries from Excessive Out-of-Pocket Expenses

Establishing limits on balance billing to low-income beneficiaries will protect those who cannot afford to pay more than the Medicare-approved amount under a fee schedule, while maintaining the basic right of beneficiaries to choose and contract with any physician of their choice, including physicians with special expertise who may charge relatively higher fees. RBRVS-based reform will also improve overall acceptance of assignment, particularly for undervalued evaluation and management services.

Patients' financial contributions to surgical care will also be substantially reduced. Based on preliminary simulations by PPRC, the reduction in Medicare's approved amount for coronary bypass surgery under an RBRVS fee schedule from $3,894 to $2,610 would *decrease* co-insurance (the amount the beneficiary must pay) by $256 ($778 to $522). Even though co-insurance for evaluation and management services would increase nominally (co-insurance for an intermediate office visit would increase by only $1.41, for example), this would be more than made up by increased acceptance of assignment for those services and the savings in co-insurance for surgery. For example, it would take 181 intermediate office visits at the slightly higher co-insurance level under the RBRVS to cancel out the savings that a patient who undergoes bypass surgery would receive through reduced co-insurance for just that one procedure. The majority of beneficiaries with Medigap insurance would also be protected from increases in coinsurance for any services.

Making Expenditures More Moderate and Predictable

Although implementing the RBRVS fee schedule in a budget neutral manner--as recommended by PPRC--will not by itself reduce expenditures, the impact on the budget of future increases in payment rates will be far more predictable than under the existing "customary, prevailing and reasonable" charge system. By tying future increases in the conversion factor to a reasonable measure of inflation, Congress can assure that price increases do not exceed that which is necessary to maintain the same level of service to beneficiaries. In addition, by neutralizing incentives that may encourage excessive reliance on certain technological services, overall costs can be expected to moderate in the long run. As long as invasive procedures are paid more for the work involved than other services, there will be an inherent bias toward doing more technological procedures--a bias that conflicts with any strategy designed to get increases in volume under control. Development of practice guidelines can also achieve future cost-savings, particularly if developed first for those services that have experienced the greatest increases in volume, such as diagnostic and surgical procedures. The proposal for capping prevailing charges for RAS services would also bring about immediate FY 1990 savings in a way that is consistent with RBRVS based reform.

Summary and Conclusions

In conclusion, ASIM strongly urges Congress to establish policies this year that would begin moving the physician payment system toward rational, long-term reform. At a minimum, such policies should include:

- A clear mandate to implement an RBRVS fee schedule beginning in 1990. Such a fee schedule should incorporate all physician services, regardless of specialty.
- Limits on balance billing for "low-income" individuals, while maintaining the basic right of beneficiaries to contract with the physician of their choice, including physicians' who charge more than the average (or some percentile above the average) under the fee schedule.
- Attainment of immediate FY 1990 budget savings in a way that is consistent with long-term RBRVS-based reform, such as by capping prevailing charges for RAS services and raising the existing floor on prevailing charges for primary care services.
- Expansion of policies to develop the knowledge to determine the effectiveness of different services. The Patient Outcomes Research bill, introduced by Reps. Stark and Gradison, represents a significant step forward in developing the knowledge needed to control the volume of ineffective services. ASIM commends Reps. Stark and Gradison for this initiative. Congress must exercise appropriate caution, however, before enacting legislation to establish national expenditure targets, which may have uncertain--and quite possibly detrimental--effects on the quality and accessibility of medical care.

ASIM stands ready to assist Congress in any way possible in bringing about comprehensive reform based on these principles.

Chairman **Stark**. Dr. Maynard.

STATEMENT OF EDWIN P. MAYNARD, M.D., PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS

Dr. **Maynard**. The American College of Physicians appreciates this opportunity to present the views of physicians in internal medicine and its subspecialities on the RBRVS. I am Dr. Edwin Maynard, president of the college and an internist in practice at the Massachusetts General Hospital.

Mr. Chairman, in our written statement we summarize how Medicare's customary, prevailing and reasonable charge rules have led both to an inflationary spiral and an imbalance between procedural and evaluation and management services. The result of a variety of attempts to correct these inherent flaws is a nightmarishly complex set of rules and distortions in the system, which have had little impact on costs.

Further tinkering will not work. The basic system of CPR payments must be replaced. The system is inflationary, and that hurts the beneficiary and the taxpayer. CPR provides inappropriate incentives for physicians' choices about what services to provide. It favors inpatient over outpatient settings. It favors urban and suburban areas over rural areas. It encourages overspecialization. It is difficult for providers and patients, and even program managers, to understand and cope with.

Recognizing these weaknesses, Congress directed HCFA to undertake research which would permit Medicare to move to a payment system based on an objective measure of the relative value of physicians' work. For the first time, the study conducted at Harvard gives us an objective measure of the resource costs of medical services. After intensive scrutiny, no one has found major flaws in the core of the Harvard work—the development of an objectively measured scale of relative values.

Those problems which have been identified—for example, the measurement of practice costs, coding inconsistencies for evaluation and management services, measurement of pre- and post-service work—are being addressed by the Harvard researchers, the PhysPRC, and HCFA, and are expected to be resolved before implementation of a new fee schedule.

With the Harvard and PhysPRC results, there no longer can be any doubt that Medicare payments under the CPR rules have been based on factors other than the work involved, and that the rules favor high technology medicine over evaluation and management services. This committee has the opportunity to provide critical leadership in enacting payment reform to develop a rational, equitable system that corrects the failures of CPR. We urge you to enact legislation this year to incorporate the resource-based relative value scale into a medicare fee schedule.

We have heard it said that the resource-based relative value scale is simply a means of redistributing Medicare revenues among different types of physicians, so why should Congress be interested in carving up the same pie in a different way? We think you should reject this line of argument. Perhaps the most important message I can leave with you today is that the RBRVS has profound implications for patient care. It may also have important implications for the size of that pie.

By favoring high technology procedures and the inpatient setting over evaluation and management services and other settings, the payment rules have influenced clinical decisions. The CPR system has rewarded doctors for performing procedures rather than taking time for careful evaluation and prudent management of the patient, and has thereby influenced their medical choices.

The RBRVS neutralizes the influence of the payment rules on the choice of therapy. The RBRVS eliminates incentives which lead to medical decisions influenced by factors other than the necessity and appropriateness of the service. This is the right environment for providing optimal care for patients. It may also help relieve the upward pressure on the volume of services, particularly the procedural services.

For these and other reasons outlined in our statement—time with patients, prudent management, appropriate services, simplified payments, and access to primary care—we would argue that the RBRVS is good for patients, and much more than simply a shifting around of Medicare dollars.

In the remainder of my time, I would like to highlight a few of the specific recommendations in our testimony. On the issue of the geographic differentials we support the PhysPRC recommendation that the fee schedule should vary to reflect overhead costs. We also support a separate accounting of liability insurance expenses.

On the issue of assignment, the excellent research of the PhysPRC makes the point that all-or-nothing proposals on either side of this issue probably are too simplistic. For reasons explained in our testimony, the college opposes across-the-board mandatory assignment. However, we believe that low-income Medicare patients should be protected from balance bills. As part of a reformed payment system, we support a Federal assignment policy that is tied to income.

While we do not have a specific recommendation on the income level which should be protected, a cutoff in the range of twice the poverty level would provide the protection of assignment for 35 percent of the Medicare population. A threshold of three times the poverty level would protect 54 percent of the elderly. Additional protection for all beneficiaries could be provided, as the PhysPRC suggests, through a highly simplified maximum charge.

On the issue of budget neutrality, we would argue that the RBRVS makes sense under any budget scenario, is essential to achieving payment reform, and that budget concerns should not derail us from implementation as soon as feasible. While we would prefer a conversion factor based on budget neutrality, we are not willing to lose long-term reform based on the RBRVS in a dispute over short-term spending levels.

Turning to the question of transition to a new system, and recognizing the need for the fee schedule to be as complete and accurate as possible, the college believes the transition suggested by the PhysPRC would be relatively simple to implement and would ease the shift to a fee schedule implemented on a date certain.

The transition period raises the question of the President's Medicare budget proposals for fiscal year 1990. In 1987, during congressional consideration of part B spending proposals, we opposed across-the-board freezes or reductions, but supported proposals that would move in the direction of appropriate prices for all services—by cutting payments for overvalued services and increasing payments for those undervalued. We were pleased when the President's budget recognized the need to continue to correct the imbalance between primary and nonprimary services. Enactment of these proposals would be consistent with the direction of reform under an RBRVS system and with the transition recommendations of the PhysPRC.

Finally, some comments on the proposed expenditure target. It's useful to recall the incentive of the DRG payments to hospitals: Beat the fixed price per case, and you pocket the difference; exceed the fixed price, and you eat the costs. The incentive works within a single hospital, the challenge is clear, the rewards and punishments are real and immediate, and the tools are within the control of hospital leaders.

In stark contrast, the actions of an individual physician can have no visible impact on achievement of the expenditure target. Any positive actions one individual takes may be negated by those of another person. The reward or punishment is vague and uncertain.

The notion of meeting some arbitrary target says nothing about ensuring the appropriate level of care. The cap may be set too high, and allow a large amount of inappropriate care that might be eliminated through other mechanisms. Or the target may be too low, and jeopardize the provision of medical care for patients who need it. The target cannot assure that services are provided appropriately, and it avoids the central questions of how much, and what kinds of care, this society should provide.

We have suggested as an alternative the use of practice guidelines in Medicare payment determinations. We believe the potential goes beyond the educational role discussed by the PhysPRC to a role in controlling inappropriate utilization of services that would have more immediate impact on Medicare spending than the proposed expenditure target.

We suggest that a proper role for government is to use physician-developed guidelines in payment determinations. We believe there is enough agreement in certain clinical areas to develop guidelines for practice that are backed by strong utilization review and payment denial where appropriate. In contrast to the expenditure target, this is real to the physician. It is controllable. If the physician performs an inappropriate service, he or she does not get paid.

Mr. Chairman, we look forward to working with you to enact rational and equitable Medicare reform using an RBRVS-based fee schedule.

[The statement of Edwin P. Maynard, M.D., follows:]

STATEMENT OF

THE AMERICAN COLLEGE OF PHYSICIANS

BEFORE THE

HOUSE WAYS AND MEANS COMMITTEE

SUBCOMMITTEE ON HEALTH

April 17, 1989

THE RESOURCE-BASED RELATIVE VALUE SCALE

The American College of Physicians appreciates this opportunity to present the views of physicians in internal medicine and its subspecialties on the Resource-Based Relative Value Scale (RBRVS). With a membership of 65,000 general internists and subspecialists, the College is the largest medical specialty society in the country. I am Dr. Edwin P. Maynard, President of the College and an internist in practice at the Massachusetts General Hospital.

Introduction

Mr. Chairman, before we address the specific issues of the relative value scale, it will be useful to recall briefly the history of third party payment for medical services. It is important to remember that the first insurance, provided through the Blue Cross/Blue Shield companies, was established to provide coverage for hospital care. Services in physicians' offices were not covered. When these were later added, payment rates were set at low levels compared to the surgical services which were the primary focus of these policies.

When Medicare was established in 1965, Congress agreed to a payment system that would reflect prevailing charge patterns, in order to overcome physician opposition to the program. Thus, the undervaluing of primary care from the Blue Cross/Blue Shield experience was mirrored in the Medicare program. The disparities worsened over the years: new procedures were developed and payments for them reflected the charge patterns of the physicians pioneering the technology; at the same time, the basic cognitive work of the physician - the office and hospital visit and consultative services - did not change substantively and there was little opportunity for these physicians to set new charge patterns.

In simplified fashion, this explains much of the inflationary spiral of Medicare's history: new procedures developed, fees set at initially high levels and never reduced, little chance to update fees for cognitive services, more and more pressure to perform more and more procedures, and little information on appropriate levels of service. The Congress has attempted to respond to this spiral through a variety of initiatives to restrain spending growth and its effects. You have placed limits on fees as a percent of prevailing charges, limited increases to the Medicare Economic Index (MEI), frozen and limited the MEI, created the participating physician program, and placed limits on actual charges.

The result of all this tinkering has been to create a nightmarishly complex set of rules and distortions in the system, but there has been little impact on costs. Further tinkering will not work. The basic system of customary, prevailing and reasonable (CPR) payments must be replaced. The system is inflationary. Out-of-pocket costs become an increasingly greater burden to the beneficiary, and program costs to the taxpayer rise by double-digit percentages annually. The CPR system provides inappropriate incentives for physicians' choices about what services to provide. It favors the inpatient setting over outpatient alternatives. It favors urban and suburban areas over rural areas. It encourages over-specialization. It is extraordinarily difficult for providers and patients, and even program managers, to understand and cope with.

Recognizing these weaknesses of the CPR system, Congress directed the Health Care Financing Administration (HCFA) to undertake research which would permit Medicare to move to a payment system based on an objective measure of the relative value of physicians' work. Congress also had the foresight to create its own advisory panel for analysis and recommendations on these issues, and it can now call upon the expertise and wisdom of the Physician Payment Review Commission (PPRC) in developing legislation. Few, if any, similar blue-ribbon commissions have contributed so much to public policy debate in any area as has this Commission, and we commend Chairman Lee and all the members for their 1989 recommendations.

The Resource-Based Relative Value Scale

We now have the initial research results from the Harvard study, as well as the refinements suggested by the PPRC. For the first time, we have an objective measure which can be used to set Medicare payments. We have a measure that reflects the resources consumed to provide medical services.

This is intuitively an attractive concept: prices which are set to reflect the work and other resources that go into providing a product or service. With the use of such a measure, payments for all services will be established in correct proportion to the resources consumed, so that the payment system does not have incentives that favor certain procedures and services over others. This kind of payment system would provide, in Dr. Hsiao's words, a level playing field.

According to the Harvard analysis, the physician's professional work is about half of the resources used in medical services. Measuring work was the major research problem facing the Harvard team, and their solution to that problem is the strongest and most important contribution of their study. They conceptualized work as time multiplied by intensity, and measured several dimensions of intensity in a large survey of physicians, using the technique of magnitude estimation. Dr. Hsiao and his colleagues present careful and convincing evidence that the survey of physicians to generate relative ratings of time and intensity for different clinical services has produced a set of values which were obtained by a reliable method and are reproducible, and which have a high degree of internal consistency and validity.

After intensive scrutiny, no one has found major flaws in the core of the Harvard work -- the development of an objectively measured scale of relative values. Those problems which have been identified - for example, the measurement of practice costs, coding inconsistencies for evaluation and management services, measurement of pre- and post-service work, specific problems for certain specialties - are being addressed by the Harvard researchers, the PPRC, and HCFA, and are expected to be resolved before implementation of a new fee schedule.

With the Harvard and PPRC results, there no longer can be any doubt that Medicare payments under the CPR rules have been based on factors other than the work involved, and that the rules favor high technology medicine over evaluation and management services. This committee has the opportunity to provide critical leadership in enacting payment reform to develop a rational and equitable system that corrects the failures of CPR. We urge you to enact legislation this year to incorporate the RBRVS into a Medicare fee schedule.

Implications for Patient Care

We have heard it said that the RBRVS is simply a means of redistributing Medicare revenues among different types of physicians, so why should Congress be interested in carving up the same pie in a different way? We think you should reject this line of argument immediately. The RBRVS has profound implications for patient care. It may also have important implications for the size of that pie.

The American College of Physicians has long argued that the profession must assure that services to a patient are necessary and appropriate. The payment system has worked against this. By favoring high technology procedures and the inpatient setting over evaluation and management services and other settings, the payment rules have influenced clinical decisions. Especially in cases where clinically the choice of therapies may not be clear-cut, the CPR system has rewarded physicians for performing procedures rather than spending time analyzing, evaluating, diagnosing, and managing the patient's problem. It has thereby influenced physicians' medical choices.

By setting payments for all services in correct proportion to the resources and work involved, the RBRVS neutralizes the influence of the payment rules on the choice of therapy. Incentives are eliminated which lead to medical decisions influenced by factors other than the necessity and appropriateness of the service. This is the right environment for providing optimal care for patients. It is also an environment which may help relieve the upward pressure on the volume of services, particularly the procedural services.

Secondly, an RBRVS-based fee schedule will highly simplify the payment system, so that patients will know in advance from the fee schedule what Medicare will pay for a service. That payment will be the same for all physicians in an area -- in sharp contrast to the present situation. The patient's anticipated out-of-pocket expenses will be clear, and that will help the patient decide whether he or she wants to request assignment.

Finally, the payment system appears to have a strong influence on physician choice of specialty. We must worry about access to internists and other primary care physicians, particularly in the next century as the elderly population swells. Medical graduates today are choosing highly remunerative specialties, and staying away from primary care specialties. The RBRVS can play a role in redressing this imbalance, by assuring the prospective internist that he or she will be compensated in the same proportion to the work involved as are all other specialists.

For all these reasons, Mr. Chairman -- time with patients, prudent management, simplified payments, and access to primary care -- we would argue that the RBRVS is good for patients, and much more than simply a shifting around of Medicare dollars.

In the remainder of our testimony, we would like to discuss a number of major questions that are addressed in the PPRC recommendations. These are issues that will be central to implementation of an RBRVS-based payment system.

Geographic Differential

We support the PPRC recommendation that the fee schedule should vary geographically to reflect overhead costs. Clearly, variations in the costs of practice are a critical adjustment that must be made in creating a fee schedule that is fair to physicians in different practice settings and in different parts of the country. It is consistent with a payment measure rooted in the resources consumed in providing medical services. We support a separate accounting of liability insurance expenses, so that the formula can be sensitive to the volatile nature of these costs and the wide differences in premiums among specialties and from one area to another.

We agree with the PPRC that an adjustment for earnings in addition to overhead is not consistent with the concept of a resource-based scale. We do not know why people locate where they do, what they value in an area, or how to turn that value into a monetary adjustment. Additionally, an adjustment which favors very large metropolitan areas may provide an incentive that runs counter to the existing policy goal of easing shortages of physicians in rural and other under-served areas and thereby enhancing access.

Having stated that as a matter of policy, however, we think that caution is well-advised in this area. There will be relatively large shifts in payments to physicians on the basis of relative value scores alone. If at the same time we eliminate the differentials among areas that are part of the CPR system - which reflects both overhead and earnings - the cumulative impact of these various shifts could lead to problems of access or decreases in assignment rates. Policy recommendations and the timing of changes must be sensitive to these potential effects.

Assignment

The PPRC has produced excellent research on the issue of assignment and balance billing. The Commission has elucidated the subtleties of assignment policy and its impacts, and their studies make the point that all-or-nothing proposals on either side of this issue probably are too simplistic. The studies may point the way to alternatives around which a consensus might be formed. The conclusions we draw, however, go beyond those reached by the Commission.

The PPRC studies show that more than half of Medicare patients face no balance bill at all, and fully 80 percent have balance bills of no more than $50. With the steady increase in assignment rates, these percentages may be even higher today. The heaviest burden falls on a relatively small number of patients who are hit in three ways: they need a lot of care, they rarely get assigned care, and their balance bills are high in relation to Medicare's approved charge. In addition, balance billing differs among specialties and, to some extent, among types of service, and appears to increase with more expensive services.

With assignment rates approaching 80 percent, and large balance bills falling on a very narrow band of patients, the data indicate that across-the-board mandatory assignment is not necessary, and the College opposes this option. Physicians have obviously concluded that, in the large majority of cases, the Medicare payment should be accepted as payment in full. Second, why should a Medicare patient who can afford to pay the physician's customary charge be treated differently from a private-pay patient or one who must pay a balance because his private insurance company's rates are less than the full charge? Third, even under the RBRVS, Medicare is expected to pay below the market in most cases. With the pressures on the federal budget, over the long-run a Medicare fee schedule may fall significantly below reimbursements made by other insurers. The retention of appropriate balance billing provides an assurance to providers if the gap between the market and Medicare becomes excessive.

The College believes there are two key elements to a reasonable policy on assignment. The first is to protect people who cannot afford the balance bill. The second is that assignment policy should be uniform. That is, it should be set by the government as the agent of society, not by physicians on an _ad hoc_ basis. Our current system forces the patient to request assignment or forces the physician to depend on a person's clothing or address as clues to his or her financial status. This system allows two people of the same income status to be treated differently in two different doctors' offices, and that is simply not equitable.

Again, the PPRC data point the way to a solution. It is distressing to find that the voluntary assignment rate (i.e., excluding Medicaid patients for whom assignment is required) for ambulatory care is only 63 percent for patients below the poverty level. Even if the current level is higher, it is less than 100 percent, meaning that some of the poorest elderly patients still face balance bills. It is also distressing that the assignment rate for those in the range of 150-199 percent of the poverty level - still a low income level - is no different from the rate for patients at 300 percent or more of the poverty level.

The College believes that low income Medicare patients should not face balance bills. Therefore, as part of a reformed payment system, we support a federal assignment policy that is tied to income. While we do not have a specific recommendation on the income level which should be protected, we do not think the poverty level is sufficiently high. That level is only $5447 for a single elderly person and $6872 for a couple (1987 figures). A cut-off in the range of twice the poverty level would provide the protection of mandatory assignment for 35 percent of the Medicare population. A threshold of three times the poverty level would protect 54 percent of the elderly.

We suggest the Committee look to the experience of Rhode Island, Vermont and Connecticut in implementing income-related assignment policies, and also to the procedures that are established for setting the income-related supplemental premiums for the Medicare catastrophic coverage program. The fears of a stigma associated with an income-related policy can be minimized through the use of an encoded card; it is far easier for a patient to present this card to a receptionist or billing clerk than to have to make an assignment request to the physician or fill out a form.

Finally, tied to a revised policy on assignment and balance billing, another alternative that would provide additional protection for all beneficiaries would be to establish a highly simplified maximum charge. We endorse the PPRC recommendation that this be a fixed percentage above the fee schedule, and not vary by physician as does the current MAAC. This would bring a level of equality or balance to the system so that those above the income thresholds for assignment would not be paying disproportionately higher out-of-pocket expenses than low income patients. It would protect those relatively few patients shown in the

PPRC analysis to be caught at the high end of actual charges and percentage of balance bill. Finally, a maximum charge may be particularly necessary for those services which receive the largest reductions under the RBRVS. We would reiterate that such a limit in a reformed system must be far more rational and less cumbersome than the current MAAC.

Coding for Evaluation and Management Services

Research on the RBRVS has made it clear that the current procedural coding system is inadequate for describing evaluation and management services. While codes for technical procedures describe what physicians do, existing codes for evaluation and management services largely describe where it is done and to whom. Visits, for example, are described by type of patient (e.g., new or established), location of service, and sequence of the care (e.g., initial or follow-up). Levels of service (e.g., brief, intermediate, comprehensive) attempt to capture the duration and intensity of the service.

The problem is that these codes do not consistently describe or capture the same activities in the same way; the distinctions are not well defined, nor intuitively obvious. The result, found by the Harvard researchers and the PPRC, is that physicians in different specialties or even within a specialty use the same code to describe and bill for very different services.

Dr. Hsiao and his colleagues found that physicians' time is closely correlated with the work involved in evaluation and management services. On this basis, the PPRC has recommended that time be incorporated into the coding system, as a proxy for measures of content and intensity of service. We believe this proposal is worthy of further examination, but we would be concerned that time as the sole measure may be prone to misuse or abuse, and less readily verifiable than other indicators. The use of time alone also raises questions about whether inefficient providers of services would be unfairly rewarded at the expense of efficient, highly experienced physicians.

We suggest that serious consideration be given to improvements in coding that rely on descriptions of the content of visits. Instead of describing visits as single services, description of the components of the visit would better capture the variety and complexity of visits. For example, case history, physical exam, evaluation services, preventive care, patient counseling, case management services, and literature review are potential elements of any single visit and vary as to their presence and intensity from one patient encounter to another. They are also readily understood by practicing physicians, thereby potentially heightening the consistency of coding.

Another important element that may help to distinguish the intensity of caring for one patient versus another is the age of the patient. It is well understood that our oldest patients, particularly the frail elderly, require more time to care for, and may be more stressful, even when other components of the visit may be similar.

The PPRC has undertaken an important study relevant to these questions. The PPRC will be asking physicians to keep records of their discrete activities in a log diary. This work should yield a fully detailed description of the work involved in the bundled complex of evaluation and management services. It holds the promise of forming the basis of a set of content codes that have enough specificity so that each particular service is coded in one, and only one, way.

Content-based codes become particularly important if, as suggested by the PPRC, specialty differentials are eliminated in a new fee schedule. Specialty differentials have been used to capture differences in the value of physician services that reflect the physician's specialty training and experience. With an inadequate coding system relying on a few categories of visits and consultations, the specialty differential has been an important means of recognizing the training necessary to treat multiple and complex diseases involving many organ systems. To the extent that the complexity and intensity of the services rendered by these physicians can be described by a new, content-based coding system, the need for specialty differentials is reduced.

Budget Neutrality

The College believes that, given the need to reduce the federal deficit, it may be necessary for Congress to consider implementation of the RBRVS under conditions that are not budget neutral. The issue of budget neutrality appears to cause confusion. Many people hear this term and think it means no increase or decrease. As the Committee knows, budget neutrality means the full projected increase that would occur absent any change in law. For Medicare Part B, this is likely to be a double digit increase.

We think the RBRVS makes sense under any budget scenario, is essential to achieving payment reform, and that budget concerns should not derail us from implementation as soon as feasible. It is the right thing to do regardless of the spending total. While we would prefer a conversion factor based on budget neutrality, we are not willing to lose long-term reform based on the RBRVS in a dispute over short-term spending levels.

Phase-In

In testimony to the PPRC, we opposed proposals for a phased implementation of the RBRVS. We particularly opposed a transition along the lines of the DRG model, in which a percentage of the CPR rate would be combined with a percentage of the RBRVS rate, and then shifted annually. That kind of transition would be enormously complicated, in an environment of tens of thousands of physicians' offices, with widely different billing capabilities.

The PPRC has recommended that, after passage of legislation to implement an RBRVS-based fee schedule, there be a two-year period in which the current CPR rates are adjusted in the direction of the RBRVS. This would be an adjustment similar to that accomplished in the 1987 Reconciliation Act, except that the RBRVS amounts would be used to calculate the percentage of the shift in each of the two years. Recognizing the need for the fee schedule to be as complete and accurate as possible, the College believes that such a transition would be relatively simple to implement, and would ease the shift to the fee schedule. Therefore, we support the PPRC recommendation, as long as it is tied to passage of legislation to fully implement an RBRVS-based fee schedule by a date certain.

Along similar lines, we would like to take the opportunity to comment briefly on the President's Medicare budget proposals for FY 1990. In 1987, during Congressional consideration of Part B spending proposals, the College opposed across-the-board freezes or reductions, but supported proposals that would move in the direction of appropriate prices for all services - by cutting payments for services that were overvalued and increasing payments for those undervalued. Congress adopted this approach in the 1987 Reconciliation Act, reducing payments for specified overpriced procedures and setting a higher payment update for primary services than for non-primary services. We were pleased when the President's budget request for FY 1990 recognized the need to continue to correct the imbalance between primary and non-primary services. Enactment of these proposals would be consistent with the direction of reform under an RBRVS system and with the transition recommendations of the PPRC.

Controlling Volume: Expenditure Targets

Recently, when we have seen editorial or other comment on the need to control Part B costs, they are frequently prefaced with a note that Part A spending has been restrained.

It is worth re-calling the Part A solution when we think about the expenditure target proposed by the PPRC. The DRG system for hospitals has a simple, direct and straightforward incentive: Beat the fixed price per case, and you pocket the difference; exceed the fixed price, and you eat the costs. This incentive works not on a national level, not even on a regional or state level, but within a single hospital. The challenge is clear, the rewards and punishments are real and immediate, and the tools are within the control of hospital leaders.

Contrast this with the proposed expenditure target. The actions of an individual physician can have no visible impact on achievement of the target. Any positive actions one individual takes may be negated by those of another person. The reward or punishment is vague and uncertain.

A second flaw in the proposed expenditure target is that the notion of meeting some arbitrary target says nothing about ensuring the appropriate level of care. The cap may be set too high, and allow a large amount of inappropriate care that might be eliminated through other mechanisms. Or the target may be too low, and jeopardize the provision of medical care for patients who need it. It is likely that the target would influence the practice behavior of those physicians who are already cost-conscious, while it is ignored by those for whom it is most intended. An artificial target avoids the central questions of how much, and what kind of, care this society is willing to provide.

Third, the concept of an expenditure target would appear to run philosophically and practically counter to the type of thoughtful, targeted approach in which Congress has shown increasing interest. It would appear to move us away from thinking in terms of appropriate price for appropriate services, and towards broad brush approaches of caps and freezes that do not differentiate the good from the wasteful.

Finally, the proposal assumes that the sole contributor to increases in volume is the physician. We would argue that patient demand is an important element, and that patients have to be brought into any workable solution to the question of utilization. Increasingly accepted precepts of patient autonomy challenge the old paternalism of the physician as sole decision-maker, and therefore, challenge the idea that the physician must be the locus of all utilization control strategies. Given the grey zones that exist in our knowledge base with regard to the effectiveness and appropriateness of various medical and surgical interventions, and the choices that frequently must be made without any guarantee of a particular outcome, the highly personal preferences of the individual patient become critical decision factors.

While physicians still direct the use of most services, with the explosion of medical knowledge it is clear that utilization is also affected by patient expectations of levels and types of services (as well as by other influences such as insurance payment policies). This patient impact on utilization can only grow -- and should grow -- as patients become more knowledgeable about health matters. If we were to adopt new criteria of appropriate care without bringing patients into that process, they rightly would react with concern at being left out of crucial decisions.

We are beginning to know more about how to bring the patient into the decision-making process. Dr. John Wennberg notes that developments in media "provide revolutionary new ways for synthesizing, conveying, and individualizing information that can support a luxurious and active cross-communication between the patient and the physician" (Health Affairs, Spring 1988). This kind of interaction will dramatically enhance the role of the patient in medical decisions and take us further down the road of patient as enfranchised consumer.

Controlling Volume: Practice Guidelines

We have suggested as an alternative to expenditure targets the use of practice guidelines in Medicare payment determinations. The College, which has been developing practice guidelines since the 1970's, before other medical specialties, first brought to the attention of the PPRC the potential role of guidelines in controlling the volume of services. We are pleased that the Commission has continued to recognize that potential. However, we believe the potential goes beyond the educational role discussed by the PPRC to a role in controlling inappropriate utilization of services that would have more immediate impact on Medicare spending than the proposed expenditure target.

The challenge in this area is not so much in creating good guidelines. We know how to do it, and more and more specialty societies are undertaking this responsibility. The problem is that we have only limited experience in the task of getting physicians to use the guidelines, that is, to change behavior from accustomed ways of practicing. There is some evidence that a central element must be education and follow-up, including peer pressure, that is brought to bear on a local level, either within a single hospital or in a community.

At this level, it appears that guidelines can have a significant impact on utilization. For example, the vigorous application of guidelines for respiratory therapy in a Boston hospital resulted in marked reductions in utilization, charges, length of hospital stay, and pulmonary complications, with no increase in morbidity or mortality. A similar effort at the UCLA Medical Center resulted in substantial reductions in the routine use of four labor-intensive and costly laboratory tests.

Until we know better how to change behavior, and can put into place these local mechanisms, a fiscal incentive will be necessary if we are to have significant impact on Medicare expenditures nationwide. We suggest that a proper role for government is to use physician-developed guidelines in payment determinations. We believe there is enough agreement in certain clinical areas to develop guidelines for practice that are backed by strong utilization review and payment denial where appropriate.

Neither Medicare nor any other payer should reimburse physicians for practices which the scientific evidence indicates are inappropriate in the particular case. These guidelines cannot be automatic screens, but should be used to highlight cases for review. The burden should be on the physician to show that the service was medically appropriate and payment is warranted.

We can choose several services and procedures now, and add new ones each year, for which research conducted under the College's Clinical Efficacy Assessment Project, or under the RAND studies, or by others indicates a high degree of inappropriate practice. We can publish and disseminate the guidelines, create the utilization review screens, and produce results quickly.

This is real to the physician. It is controllable. If the physician performs an inappropriate service, he or she does not get paid.

In proposing the expenditure target, the PPRC says the purpose is to elicit cooperative behavior among physicians in deciding on appropriate practices. If this is the purpose, why use that very remote mechanism? Why not simply start to identify those areas where research has been done, or is underway, and adopt professionally-developed guidelines as Medicare policy -- with the fiscal incentive of utilization review to back them up?

Conclusion

Mr. Chairman, you have the opportunity to enact legislation that will have profound impact on the Medicare program and the health delivery system generally. You have the expert advice of the PPRC to call upon as you formulate legislation. The American College of Physicians stands ready to assist in this task as well. We look forward to working with you to enact rational and equitable Medicare reform whose core is the RBRVS-based fee schedule.

Thank you for this opportunity to testify.

Chairman **Stark**. Thank you very much. If I could take care of a couple of housekeeping things for a moment, it is my understanding that there will be a series of three clustered votes at approximately 2:15. It would be the Chair's intention to recess at the second call and reconvene as quickly as we can after the completion of the third and fourth vote on suspension. Whomever returns first can take the gavel.

Second, the red bulb burned out. The only way you will get me off stage is to remind me when the green light goes out my time is up. It is our intention to have a second round.

I wanted to ask a couple of questions of the witnesses.

In my county, Alameda County, CA, rationing has reared its ugly head. We have hired a retired Jesuit to the tune of $50,000 a year to be an ethicist and to ration. It seems somewhat obscene to me. I saw on TV last night that a great deal was made about a 3-year-old child who received a kidney or a liver because another 5-year-old child passed away.

Rationing is abroad in the land, but as one member of this committee I do not want to be involved in it. I think that is something that if it ever does come has to come from your profession, not ours.

In your discussion, Dr. Maynard, you mentioned an encoded card and Dr. Boyle indicated he thought there would be ways to determine income. It brings up another issue. If, in fact, we are going to deal with the resource based relative value scale and if, in fact, we are going to keep track of more information, we are going to have to deal with that philosophical sword of Damocles which is a data base and the Federal Government collecting information not only about our beneficiaries but about the time you charged them for and the procedures that you will bill.

That has been a problem in the past. There has been this idea that we cannot have a huge bureaucracy collecting information and it is against the way you choose to practice medicine. I understand that.

But I think to suggest we don't go forward into the 21st century with that information available to us, protecting the rights of privacy and the doctor's ability to practice medicine, however they choose within their own professional review, we are not going to get anywhere. We are going to have to keep track of prescriptions at every pharmacy in the country. Major credit card companies tell me they have far more than 30 million credit card members. They can tell me when I leave the tie store and get down to the shoe store even if I run, they can tell if I am over my limit and they will not allow me to charge.

If Visa or Mastercharge is able to keep such tabs on me, perhaps there could be some benefits. It is something professional representatives have revisited, hospitals have revisited. Government has revisited it on a philosophical basis. I think it is implicit in all the things we are talking about.

I hope as we negotiate and work together, we can deal with how to collect this data and how it will be used because I think we cannot really do without it. I hope you will work with us on that.

I heard two conflicting pieces of testimony on urban and rural. That has always been a political decision reserved to this committee. Usually we sometimes are balanced out by the Senate. We are an urban committee on balance and the Senate is a rural committee on balance. I would hope that among yourselves you could come to a less political decision that would help us.

It doesn't seem to me that this is properly resolved as a political issue. There is some disagreement among the witnesses. I hope you will be able to work on that and find a consensus, if there is a rural-based internal medicine group opposed to an urban-based, I hope you can come together.

It is difficult for me to see other ways to project savings. I would hope that in time you all would decide that in the broad spectrum of medical specialties. I hear often that among the primary care physicians you could probably decide, what if we did this, and let me give you a proposal today. Let's suppose that we had three groups that I will call primary care physicians, surgeons, and hospital-based physicians—I gather those distinctions are in the vernacular today, and those three groups negotiated for their share of a total cap with PhysPRC.

Instead of 14 percent with the CPI at 5 percent, let's talk about a 10-percent increase and then PhysPRC and our committee agree that they come back to 3 groups, not 15 but 3, is that a better way out of the box than just an overall cap or doesn't that do us any good?

Dr. **Boyle**. Mr. Chairman, the view that we have of our profession is that the services available to patients are a continuum. As a consequence while I recognize that there is some logic in trying to separate services for purposes of limiting volume available, it does mean that, assume that people who provide eye surgery are limited to X volume because that is all the money that people want to provide and I as an internist have a patient going blind because of a need for an interocular lens, I would certainly want that lens available for my patients just as sorely as I would want to be able to provide the kind of counseling that I need to for a patient with serious diabetes or extensive cancer or something else.

It is our view that the Congress would do best to look at the profession as a whole and say we ought to treat you all the same. I think this also goes on over into our view about rural and urban fees. We believe that there ought not be any difference other than actual demonstrable costs. We agree with you that it should be cost, not style.

I think that Dr. Graham and the Academy of Family Physicians is right that if there is no difference in costs, there is no difference in opinion. If there is a real difference in trying to provide service with no difference in cost, they believe that we ought to be treated the same. I recognize why surgeons might want to be treated differently but on the other hand it is far better that the profession continue to be recognized as a profession where all services are of equal importance.

Chairman **Stark**. Then I gather you would say if there was an institution in existence and I don't think there is one, that as they do in Canada, for instance, they take a gross figure and argue or decide among themselves and I guess suggest adjusted fees to control the aggregates among themselves, the physicians and the subspecialties, that if there were some professional society in place that had the kind of discipline or loyalty, that you would prefer seeing that than having someone deal with a governmental agency.

Dr. **Boyle**. Canada is a good case in point.

Chairman **Stark**. If the bottom is too high, we might have to drop all the fees in the hope that you all will figure it out, that is the bargaining position with us, to present evidence and say wait a minute, a 4- or 5-percent increase is causing a shortage and as a group you and the surgeons and hospital-based people can all agree to that, then that is the argument for next year's total cap increase.

I don't think we are capable. I am certainly not, when deciding between ophthalmologists, some of them say people do this far too soon. The guy really needs reading glasses like mine and they do the operation when conceivably it may not be necessary.

How are we to know that?

Dr. **Boyle**. We believe that there is an absolute essential need to address the question of appropriateness of care based upon some objective evaluation of outcomes. We don't mean study this today. As a matter of fact, Dr. Chassin, who was part of Dr. Brooks' team at RAND now has commercially available a computer program which would allow people to put those kind of practical guidelines into place in a proper fashion.

If Dr. Brooks is right, the savings that could be effected almost instantly would be approximately $500 million. We believe that the work that is now in progress of trying to evaluate an increasing body of knowing would give you the possibility of seeing to it that only appropriate care is being provided and effect the kind of savings that you think are necessary without putting the kinds of controls on that are currently in place in Canada.

Canada is an appropriate case in point. A person very close to me today would probably be dead because of the need on the part of a neurosurgeon to have instantly available the kinds of radiological service to allow a diagnosis to be made and permitted her to be operated on in a very, very timely fashion. In Canada that would not happen today.

Chairman **Stark**. It could not happen in Los Angeles. They have one MRI on every street corner.

Dr. **Boyle**. In Billings, MT, it probably would have.

Chairman **Stark**. North Dakota has more MRI's than the State of Hawaii. Hawaii gets along with one. It is either North Dakota or the other that has four or five.

Dr. **Boyle**. Chances are that it would have been provided in Billings, MT, but not in Edmonton.

Dr. **Graham**. Since this is one of the few areas where I think our two associations have some degree of difference of opinion, let me expand on my comments for you. We believe that the idea of rationing, the words that you have introduced, is not a new idea. It has been with us. It may be moving from implicit to explicit as given instrumentalities of government say we have a limited amount of resources and a beneficiary group. That is pointed out in Oregon and various counties in California.

The concern that we have if that becomes part of the Federal strategy and if there is a simple target, single expenditure target, is that we know historically certain classes and categories of services and procedures for the last 10 years have been growing far more rapidly than other classes and categories of procedures and they tend to be on the high end.

I am not comfortable with the implications of that for beneficiaries and patients I represent. If you have one end of the target and it doesn't get to grow in double digits and the management services do not grow, where is it going to come from? It will come from the reimbursement available for those services which to me are basic medical services.

Chairman STARK. To accept the Canadian result—and there may be more examples—but I bring it up because it is the only model, but it is not necessarily workable here.

The result is that there are more primary care physicians relative to surgeons.

Dr. GRAHAM. That is not the result. That is the antecedent. The ratio of primary care physicians to nonprimary care physicians in Canada is 2.5 greater than in the United States. That has had a profound effect.

Chairman STARK. Do you think it would always have been there?

Dr. GRAHAM. There is no question about it.

Chairman STARK. Why is that?

Dr. GRAHAM. We are now getting back into the hearing you had last week which is graduate medical education, reverse incentives and differentials that have been in the United States but did not take hold in Canada in the same way.

Where Dr. Boyle and I may be in some disagreement, we do not see the imposition of three or five classes of expenditure targets meaning that a neurosurgeon is not available in Los Angeles and an interocular lens is not available in Billings.

It may mean over a period of years if those are the category of services which grow at double digit while office-based services are not, while the providers of those services will receive less of an adjustment in their reimbursement. It doesn't mean IOL's go off the market. It means that the increase is deflected downward.

I think that is substantially different than saying you cannot get an IOL for your patient.

Chairman STARK. I could not agree more. That is the result. The only issue is who is going to bargain. I would feel more comfortable if you are bargaining over the care my mother will receive if you fight with the ophthalmologists rather than myself.

You know more about it.

Dr. GRAHAM. I think there are considerable differences. Dr. Boyle practiced in California when they ran into that problem. The potential role of the PhysPRC to continue to be a focal point for discussions in the community and to be an advisor to this committee and other appropriate committees in the Congress may be in the face of FTC's authority to be the best compromise answer. If we were released from those bounds and it were possible to structure a way for organized medicine to sit down and do that negotiation that would have a lot of attractive attributes, but they are not there now.

Dr. MAYNARD. I would like to add that, as opposed to the expenditure targets, we would reemphasize that guidelines based on sound practice research can be adopted and have proven to be effective.

Chairman **Stark**. Is there any reason you cannot do both? I know Mr. Gradison and I are concerned about outcomes and effectiveness research.

Dr. **Maynard**. We are strongly in support of that. We do not believe that the divided types of expenditure targets that you have would be practical or appropriate. I think physicians work as teams. They don't work opposed to each other.

Chairman **Stark**. I agree with you but it is a matter of indifference to me. Somehow a structure has to evolve. Let's say there are three major groups, primary care physicians all stay together and the pediatricians don't strike, all the surgeons stay together and the hospital-based physicians stay together. Somehow it seems to me there has to be some interaction between those groups rather than 20 specialty groups getting together.

Somehow if someone is more comfortable having all primary physicians bargain for how well distributed the reduction is, let's assume something passes and we are down the line because last year, the previous year you did not hit the target for the aggregate amount. So we have to cut the fee schedule 5 percent across the board as a penalty or raise it 5 percent across the board.

Maybe you guys came in under the target. That should not have an effect on next year's cap. But at some point there has to be a place where you can sit down and let's assume for a minute. This is breaking the whole fund. How do you get it? I don't care. You can get to that discussion any way you want with some independent group.

If you work it out, you are home free. I don't think the procedure should be that we have to decide that this year we will go after ophthalmologists and the next year after proctologists and the next year pediatricians. We are not qualified to do that.

I am willing to accept any way you can but I am hearing from several groups that they want to plead their case independently but they are still pleading against you or with you.

You are going to have to challenge them. I am saying keep the divisions as small as you can.

Dr. **Maynard**. To respond to your example, Mr. Chairman, you raise the question of gallbladder surgery. The American College of Physicians has worked in conjunction with representatives from general surgery to define the appropriate indications for such surgery.

They work together and have come up with useful guidelines as to those indications. These are changing and will continue to evolve.

Chairman **Stark**. So now it is the two of you against the radiologists. Is it necessary to have 16 pictures of my gallbladder from the top and the bottom and four directions on each side or can we get away with two or three? I mean, you all have to argue that out.

You have got one step further to go. That may be the issue. As long as that kind of agreement can be worked out, I don't care how you get there.

Dr. **Maynard**. This type of a decision is being worked out every day with collegial groups which will include the radiologists in any such decision.

Chairman **Stark**. That seems to be——

Dr. **Boyle**. Dr. Maynard is talking about developing guidelines for practice, which we all agree is appropriate.

Chairman **Stark**. But not caps?

Dr. **Boyle**. But when you come down to the point of who is going to ration care, I don't know whether you read the——

Chairman **Stark**. We just decided we are not going to ration care, we are just going to lower fees, but which fees get lowered? Let's talk about it that way.

Dr. **Boyle**. You are talking about how to ration care.

Chairman **Stark**. No, I am not. It is only lowering a fee. There are two ends to that. You can ration care or lower fees. There are two ends. One is the opposite of the other.

Dr. **Boyle**. I realize that. It is our judgment that you ought to have one conversion factor, and that is the way you ought to approach fees.

From the standpoint of rationing care, I don't know whether you have read the book called The Painful Prescription by Aaron and Schwartz. If you have not, I will try to get a copy and send it to you.

Chairman **Stark**. Be sure it costs us less than $100.

Dr. **Boyle**. It is a little tiny book, only $7 or $8. You can read it very quickly. I direct your attention to the question of providing total parenteral feeding for patients in which the question is asked how do you control that. And it says, well, if one doctor happens to be using too much of it, his colleagues come to him and say, look, you are taking money away from my patients. Why don't you stop—in essence saying why don't you let your patient die because I have got another patient I have to take care of.

I don't think you want the profession to be in that position.

Chairman **Stark**. I can't see that happening, but I have taken far more time than I should have. My colleagues have been patient. Was that the second bell?

Mr. **Levin**. The lights are wrong.

Chairman **Stark**. OK. Mr. Levin.

Mr. **Levin**. Thank you. Mr. Chairman, as one sits here listening to discussions, it is pretty clear how far the debate has moved. We are a long ways away from a number of years ago. I think that is a reflection, a positive reflection on everybody in the profession, those of you who have been at this much longer than I in this field on both sides of the aisle have tried to come to terms with the problem, and if we are not going to have a comprehensive single system, how do we make kind of a piecemeal structure work?

It strikes me that in addition to the changed atmosphere there are a couple of other things. First, everybody is going to have to pursue their self-interest now that we have gotten beyond the gulf that used to so badly divide us, but in a very enlightened way or else we are going to be back where we started.

My guess is that is kind of what we are looking for. We accept self-interest. We hope it will be enlightened. I think, therefore, we will look to see the extent to which your specific positions reflect your financial self-interest and look for instances where maybe there isn't a perfect match, where you may be able to accept something, if not propose it.

It may not be completely parallel to the finances, and so I say that it is within that spirit that I, for example, raise the issue of geographic differential. I am in basic sympathy with the family physician function and its approach, its role, but it is hard for me to understand how we could ever vote for a structure that had absolutely no reference to cost, where there would be no geographical differentiation at all.

And when I look at the charts, the RVS charts and look under family practice, there is a striking differentiation in the two charts where you take into account geographic differentiation and you don't. The group of those that would gain shifts where you take into account the geographical factor.

I am not sure I read that with complete accuracy, but it would appear to be that way. So let me just ask you, Dr. Graham, you have people in different settings, some of them—it is kind of common sense and I am not going to vote just for an urban differential because I am from an urban area.

Last year I was in a fight that helped some rural hospitals where it seemed to me to be in order, but it is kind of common sense to take my own State. It is going to cost more to practice in West Bloomfield than it is in Sturgis. I just know it. I have had the chance to be in Sturgis and to be in West Bloomfield, and I know the rents are different and some other things are different. It doesn't matter exactly whom I represent because I represent an area that spans some different cost differentials, how I can say to people who are doing the same thing that I will not take into account your costs.

Dr. GRAHAM. We believe that some of the data that was used by PhysPRC may not be correct data, and as a matter of fact their conclusions in terms of cost are at variance with some other cost data.

Now——

Mr. LEVIN. Then we will get better data.

Dr. GRAHAM. Let me tell you how I sort out some of the Bloomfield and Sturgis questions. You look at West Bloomfield or you look at the metropolitan areas of the State, and you say rents are higher, other cost-of-living factors may be higher, what, housing, what have you.

Mr. LEVIN. Also income, salaries are higher because those people, I mean, there are lots of thing—it costs more to live in West Bloomfield than it does in Sturgis.

Dr. GRAHAM. As you get into the data, that may be one of the areas that you find some unanticipated results and that is because of the scarcity of certain types of skills in the less metropolitan or rural areas. it costs more than it does in the urban areas where those skills are more available, to hire a lab tech, to hire a radiation tech.

What are the costs of practice if you are practicing in a three-county area and you have to drive 40 miles each way to the three hospitals that you try to provide services in, versus the fact that you practice in an urban area, the three hospitals you practice out of are separated by 10 miles?

Mr. LEVIN. So we maybe should take that into account, but it is common sense. It seems to me, and we know more than just common sense, that even if you take into account the greater transportation costs or whatever, that there is going to be a differential, and it can be a somewhat substantial one.

I don't want the differential to draw in excess of physician and other medical services, but I, in good conscience, can't look at my colleague from the Boston area and say that it costs the same to practice the exact same service or the exact same type of effort in Boston as it does in Menominee.

Dr. **Graham**. But what I am suggesting to you is that as we have looked at the cost data and particularly for the reasons that I started to outline for you, some of the things that you would think common sense turn out not to be.

Mr. **Levin**. I agree with that, but I think in a sense you are alleging because I am not saying that all the data are correct. What I am saying is that it seems to me that if we are going to be fair about it that there has to be some reflection of cost and if we have inadequate data, we ought to secure correct data.

Dr. **Graham**. That is what I am suggesting.

Mr. **Levin**. We aren't going to be able—this gets to my second point. I want to move to it quickly. We aren't going to be able to move in on complicated issues of utilization and with all the data that that requires if we can't obtain adequate cost data for various parts of the country.

That's relatively simple. And if we don't have accurate measures today we should secure them. But it seems to me if we are going to now take this spirit that I think exists and come to terms and come to agreement that everybody is going to have to kind of check and be sure that what they say is more rational than it is rationalization, and I think that to simply dismiss any reference to cost in a formula is unsustainable in a country of this size.

Second, and I will be very brief, and I say this, as you can see, within a positive spirit, and I hope it is taken that way. I could pick other examples, too. That one just stuck out. Mr. Moody and I were reacting to the comment about the geographic differential.

Third, just a quick question, and maybe you can give me a quick answer, almost yes or no, because of your wealth of experience. I would prefer in a sense that we not have expenditure guidelines because they are a rather coarse way to allocate resources. But we can only avoid them if we really can control utilization directly, and the experience in this country has been rather despairing or rather tentative. Let me put it that way.

So let me ask the three of you. Do you really think within the next year or two that we—and then in the future years—that we can evolve a system where utilization can truly be restricted in terms of need and quality by guidelines or utilization reviews? Are you saying put 100 percent of your weight on that?

Dr. **Maynard**. May I respond, Mr. Levin? The college believes that the proposed RBRVS contains the incentive through proper determination of costs to help discourage the overutilization of high-priced procedural services. But to look at the basic question of developing guidelines, based, again, on sound practice research, yes, we do believe that a major expenditure of time, effort, and money by the physician community should be directed in this fashion.

We are convinced that such studies will help to control costs. They do so on an educational basis by helping to change the practice patterns of physicians, but they can also be utilized in appropriate utilization review and in payment denials.

Mr. **Levin**. I agree. But is it enough? I mean, are you really saying put all your examples in that basket or——

Dr. **Nuckolls**. Let me respond from this end. I think the answer is, yes, I think it can be done, but the profession can't do it overnight. I think that we are on our way to developing guidelines, but doctors aren't taught that way. We are not taught in medical schools and residency programs under guidelines. We are not taught to omit tests. We are taught to do tests.

If you are penalized, you are penalized for errors of omission, not errors of commission. So I think we have a major realignment to do in our educational programs. Likewise in the practice situation. Because of many different expectations of the public, liability concerns, and the attempts to practice contemporary medicine, we still have the problem of never really following practice guidelines.

We have had to input a little with the development of the PRO Program that be have seen guidelines that we really haven't seen. We have been evaluated by guidelines that we really don't see or don't know exactly what they are because they tend to be in the minds and concepts of the individual PRO's, and so the profession is slow in coming around this way, but I think it is the way to go. I think we can do it, but I think it will take a major effort on our part and both the university training programs and in the practice situation to evolve into guideline practices.

Mr. **Levin**. Are you saying it is not a——

Dr. **Graham**. Our comment would be very close to what Dr. Nuckolls has said. Since there have been two positive comments, let me be a little cautionary just for balance. There is a danger in these discussions. I think practice guidelines are the medical equivalent of room temperature fusion.

It is a very attractive idea, with tremendous positive implications, and we are in the romance phase with it right now. We are following very closely the work of people like Brook, Chassin, Wennberg, Eddy, and others. It may work out. It may be something which, when put into the education system, and the continuing medical education system, will be something that, without the restraints, of regulation will move medical practice in a positive area, and we are investing considerable resources of our own association to work in that direction.

I think it should be supported. I think it is worthy of the Commission's attention and support, but I think we also need to keep in mind it is at the romance phase of an idea right now, and I would hate to see it become sort of the answer for everything in the tough choices that you have to face that, oh, we don't need to worry about that because guidelines will take care of it.

Until we see Dr. Chassin's software work for 3 years, we don't know whether that is an answer or another problem.

Mr. **Levin**. Thank you, Mr. Chairman.

Chairman **Stark**. Mr. Moody.

Mr. MOODY. Thank you. Could the three of you just summarize again quickly why you don't think expenditure targets are a good idea?

Dr. BOYLE. Mr. Moody, I think first of all, that as far as we are concerned, expenditure targets probably represent the worst of all worlds to patients. It presents the world in which there will be—as Dr. Graham indicated—explicit rationing of service. It also presents the problem that individual patients may be denied care by a particular physician because that physician is bumping up against somebody else.

We believe that in the long run, as the Congress finds it is increasingly necessary to find savings of one sort or another, it can only be done by reducing the aggregate levels of money that will be available. We believe that in those countries in which expenditure targets have been used by government as a matter of public policy to control costs, England is one. Canada is another—that you can see the evolving—you can see the evidence clearly in England and you can see the evidence evolving in Canada where the answer is that regardless of whether it is the profession or government or anyone else that is developing the rules, sooner or later there are long lines and there is denial of care.

We believe that there are other strategies that offer some better opportunities, strategies such as trying to have more effective data control. The chairman pointed out that we have the opportunity today to develop enormous data bases. Emerging the data base from part A and part B of Medicare, as an example, provides an opportunity to use some of the technology that has been developed by Dr. Brooks, Dr. Chassin, Dr. Wennberg, so that we can truly evaluate what care is appropriate, what care people really will want and need to compare not the effectiveness necessarily, the efficaciousness of competing systems or methods of providing care.

So we think this is probably the worse direction to head at a time in which we are on the brink of bringing a more rational approach to the manner in which services are provided to individual patients in a whole variety of settings.

Dr. GRAHAM. Nobody that I talked to in the profession is as enthusiastic about expenditure targets. We view that the proposal placed before you moves those targets from offstage to onstage. The Congress has been dealing with expenditure targets in Medicare from the start of the reconciliation process. That is exactly what you have been doing.

When somebody has said——

Mr. MOODY. You have seen the newspapers. We just agreed to cut, or Congress has agreed to cut $2.7 billion out of Medicare. That is a very macro expenditure target but it is still a target.

Dr. GRAHAM. We are into our seventh reconciliation now, and you have been doing that. The difference in view you hear me reflecting from that that Dr. Boyle may be reflecting I don't think is a difference of view of our members or our association in terms of the implications of limited resources. Physicians, as Dr. Nuckolls indicated, are taught not to limit resources but to try to find maximum resources to the good and to the interest of the patient.

Unfortunately, you are in a position where there are limited resources to be allocated to the purpose of Medicare. I believe the proposal that has been put in front of you would cause us as a community to start dealing with aggregate resources in an explicit fashion and saying what our priorities are.

I don't think it is going to be comfortable, but as long as you are going to keep doing reconciliation, I would rather have it right out on the table where we can all talk about it rather than where it has been for the last 7 or 8 years.

Mr. MOODY. You think it is wrong for doctors to face resource restraint problems?

Dr. GRAHAM. I would have to say as a matter of public policy I don't know why it is any wronger for us to face it than any other profession that has to deal in an economic environment. I think for physicians, because of the mindset of our education and because of the relationship with our patients, it is extraordinarily difficult. If you are selling me a new car and I can't afford it, well, that is the way it goes. Not everybody can afford the car you are selling. But if you are a heart surgeon and I can't afford the bypass, that affects you and we in very, very different ways, and I think that is why it is more difficult for physicians, but do I think it is wrong? No, I think that is one of the unfortunate realities of the latter part of the 20th century that we as physicians have to recognize.

Mr. MOODY. So your difficulty with expenditure targets is not nearly as severe as the other gentleman.

Dr. GRAHAM. I think we do view those differently.

Dr. MAYNARD. I would view expenditure targets as yet another form of rationing of services. I think in our country today we are faced with just the worse form of rationing available; namely, the unavailability of medical services to many of the poor population in our country. But the focus of our discussion today is on the Medicare population, which does have many of its services covered.

We at the college, again, do not believe that an expenditure target, either at an overall national level or at a differential level between services or groups of physicians, is appropriate because it seems unworkable. I do not believe you can come out with any reasonable agreement or argumentative differences between groups of physicians.

I would only come back to our belief that guidelines are at a conceptual state of development. Now these have been shown to work. They have been shown to work in my community, in Mr. Donnelly's community, where the New England Deaconness Hospital is located. They took a look at respiratory care services, developed guidelines there and have saved the community an enormous amount of money with these being complied with.

Similarly in Los Angeles, guidelines developed there have been implemented and have saved a vast amount of expenditure in laboratories. These are here. They are workable.

Mr. MOODY. They are not universal at this time?

Dr. MAYNARD. No, they are by no means universal, but they are spreading widely.

Mr. MOODY. But they are beyond the experimental stage?

Dr. MAYNARD. Well beyond.

Mr. MOODY. Would you agree almost exactly with what the first gentleman said?

Dr. **Maynard**. My opinion and Dr. Boyle's opinion are totally congruous.

Mr. **Moody**. Why is it that we who are deciding these matters without much medical knowledge are supposed to make explicit resource restraining decisions. Why isn't it appropriate that you who have the most knowledge should participate in the expenditure target decisions, as good as practice guidelines may be? Why is it is not appropriate that you, with the most knowledge, fine tune those decisions at the level where they count the most, when we are forced to do it with a lot less knowledge?

That is permanent. We are forced to do it.

Dr. **Maynard**. Because you are faced with the determination of how major macro decisions should be made. We are faced with a decision as individual practicing physicians about what our expenditures should be on behalf of individual patients. We do not find it acceptable that we as physicians should be making major societal decisions as to the rationing of health resources.

These are decisions that really need to be made with multiple parties, including the patients and public at large.

Mr. **Moody**. I didn't mean to say you should be voting on reconciliation packages here in Congress, as nice as it would be to have your votes. Rather it is just that we are doing that, and we don't just make them in the macro sense, we end up making them in a lot more detail than that, such as with overpriced procedures. You have seen us go after those.

We are making decisions beyond the macrolevel. Wouldn't it be appropriate for you to make explicit tradeoffs, too? I know you don't want to. Who wants to? But isn't it appropriate?

Dr. **Maynard**. We have joined with you in the indication of overpriced services and have concurred with your recommendation to reduce your expenditures for such overpriced services. We think that the compiling of cost reductions should continue.

Mr. **Moody**. Let me just quickly ask each of the four of you what is wrong with the Canadian system for us. What would be wrong about transitioning into a Canadian-style system right here? I know you would rather not make explicit decisions. You have been making them implicitly through the guideline approach. What would be the major disadvantage?

Dr. **Maynard**. I will continue, and I would say that the American College of Physicians does include the internists in Canada as well, so we have a great deal of exchange with them as well. Recognizing the pluses and minuses of their system, but to oversimplify the problems, they are those of the expenditures of money, the great limitation whereby they are expending approximately 8.5 percent of their GNP as opposed to our figure in the 11-percent range.

The major negative comments are——

Mr. **Moody**. You can call that a negative or a positive.

Dr. **Maynard**. But as to the impact on patient care and health services in Canada, it has already been alluded to that a lot of the capital equipment is in very short supply and this can have a major negative impact.

They also have some significant negative effect on their educational product in Canada, a good deal of limitation on research moneys and again on major hospital equipment.

Mr. **Moody**. Let me ask all three of you to just untangle this. The Canadians have decided to put less resources in. They are at 8.5 percent of GNP spending on health. We are at 12 percent. The other issues are incentives and the behavior. Please leave out the resource issue for Canada, unless you think something inherent means they spend 8 percent of GNP where our system means we spend 12 percent.

Let's leave resources out. If we were to adopt their system, what would be so bad about it?

Dr. **Maynard**. It comes down to the Canadian physicians being limited to a certain point, depending on which Province you live in. Yes, I think there are some aspects of their system which work well.

Mr. **Moody**. And would work well here?

Dr. **Maynard**. Perhaps.

Mr. **Moody**. Other than the resources available, what would not work well here?

Dr. **Maynard**. I think it comes down to the problem of where you cap the service that can be expended by an individual physician in the community. One, this is determined by what may be available to them, and they are certainly limited if they do not have the hardware and the expensive technology available for the expenditure. And, second, it is determined also by their income incentives which are certainly blunt.

Mr. **Moody**. Dr. Boyle.

Dr. **Boyle**. There are two aspects of the Canadian system, as I am sure you are aware, the first of which has to do with payment for hospital services in which a global budget is provided. I think that the weaknesses of that system are becoming more and more apparent as there is now increasing difficulty in obtaining certain kinds of services, sometimes reasonable basic services as we see it in this country in some relatively large communities.

On the physician side, you have another set of problems, and that is that there is an aggregate sum of money which is negotiated between the parliamentary government and the parliamentary medical society. The medical society then negotiates within itself as to how those services will be divided.

In Canada the medical associations have far greater control over what the members of that profession do. In many instances they are the licensing or certification bodies. They are the ones who are anticipating will provide professional discipline.

Neither of those authorities or responsibilities exist in this country. Second, in Canada whereas they may set certain limitations on the fees that will be provided for certain services, they do not have any authority to control the volume that is provided within each of those specialities or by reach of those specialists within a different subspecialty, and that creates a peculiar set of incentives.

As an example, when I was in practice in Los Angeles we had some pulmonologists come from Canada to Los Angeles to practice who were very severely dissatisfied because they all of a sudden were expected to provide some element of continuing care, whereas in Canada all the provided was the consultation. Somebody else took over that care.

Third, in this country it would be extraordinary—it almost is beyond my imagination as to how be would go about saying to physician A, who is a very conservative economical, careful physician providing services on the most highly appropriate fashion that he or she is now going to be penalized because physician B still practicing sort of within an acceptable limit is far more liberal in application of service and far more likely to expend the sources or how would one want to go about as they do in Quebec where they say there is an absolute limit on the aggregate sum that an individual physician may obtain an income during any quarter of any year.

It is done also in some other provinces and say to the patients of a physician, OK, I have worked now for the past 8 weeks or 9 weeks or 10 weeks. The money is up. I am going on vacation.

The complications of the application of that system, at least as we see it, would be to the disadvantage in the long run of the patients for which we are providing care. It is an extremely seductive and attractive notion. In act, there have been many physicians in this country who said why don't we just sit down, negotiate with the Government for a fixed sum of money, and then we will divide it up. I mean, there have been people who have espoused that for a long period of time. When you evaluate it, it is usually those who will be more likely to exploit the system who think that is a good idea than are the conservative physicians who are really concerned about taking care of their patients.

Mr. MOODY. Dr. Graham.

Dr. GRAHAM. Mr. Moody, I think the previous two answers covered a number of points that I would have made. Let me try to talk about a couple of different ones. You said what would be the difference? What would happen? You then asked that we separate off the resources question, which is——

Mr. MOODY. The incentive question, the behavioral question.

Dr. GRAHAM. Part of the reason the Canadian system is the Canadian system is because of the decisions they made about resources. It is easy to be overly simplistic about the Canadian system. Those are folks who kind of look like us and talk like us, and so we assume that their system must be applicable.

The Canadian culture is a different culture than the American culture in terms of expectations, of social systems, and social policy. The medical culture is a different one. One of the first things I would anticipate that would happen in the United States with the imposition of the Canadian system is that you would see a tremendous upheaval in the Nation's medical schools.

It goes beyond just applications of resources to research. When you look at why the change, in my view, why some of the changes were able to take place in Canada back in the sixties, that might be very difficult to bring about in the United States is because you are dealing with a population of practitioners who were at almost 50 percent generalists.

And that is a very important part of the American medical culture. Canada does not have the investment in research and the investment in technology that the United States has. That would be something that would be different. Would that be acceptable to our population? Would it be consistent with their expectations of the American health care system?

I would submit to you it probably would not be until after a tremendous amount of reeducation and probable a lot of unhappiness. I do not disagree with what either of the first two speakers have said. The Canadian system needs to be understood in the context of the Canadian culture.

It has worked well for them. I respect what it has accomplished. It serves as an organizing point for some of what I think we should do better in the American system, but I would no more try to implant the Canadian system in the United States than I would the German system.

Mr. **Moody**. Well, I guess it sounds as if the three of you wouldn't disagree with the idea that if we were going to contain overall medical expenditures in Medicare that some behavioral modifications will be in order. High-technology medicine is probably going to have to be somewhat attenuated to keep our costs in line.

Would you all agree with that?

Dr. **Boyle**. One way or another, yes, sir.

Mr. **Moody**. All three of you seem to support cost-based payment systems. Is that a consensus from your test? It seems to be.

Dr. **Maynard**. Yes.

Mr. **Moody**. Thank you.

Chairman **Stark**. Mrs. Johnson.

Mrs. **Johnson**. Thank you, Mr. Chairman, and, regrettably, my apologies to the panel for not being able to be here earlier to hear your testimony. There are just two things I want to follow up on. One is on the issue of a geographic multiplier.

In my part of the country in the Northeast, I spend a lot of my time fighting for recognition in the Federal bureaucracies of the cost in New England, the cost of purchasing services, the cost of purchasing housing and so on and so forth.

It is dramatically higher. It is so much higher that we have lost every kind of personnel from our VA system and so on and so forth. My FBI agents start at a salary that is below what foot patrolmen start at in New Haven, CT, so you can see the dimensions of the problem.

I can hardly imagine that there could be any national payment system that didn't have to take into account that physicians pay more for malpractice insurance, more for help, more for leasing space. I dare say that a comparison of the costs of practice in New England would reveal stark differences between those costs in New England and some other parts of the Nation.

Perhaps they are higher even in some other parts of the Nation, but I think that to have a payment system that doesn't take into account regional accommodations as imperfect a public policy tool as that has proven to be wouldn't make sense, and I wonder what you think about that.

I know my colleague from Michigan pursued it. I am looking at it more from the point of view of nonmedical costs of doing practicing.

Dr. **Graham**. Representative Johnson, let me respond first. I think the test that holds out as to whether geographical differences should exist, the point that we try to make is that within the rural/urban bounds we question very much whether or not the PhysPRC proposal to amply pay more to urban physicians because their cost of practice is greater than rural physicians is, indeed, based upon fact.

PhysPRC developed and worked with a certain data base. We have worked with other data bases. Those data bases are different. What Representative Levin and I discussed and had, I believe, some difference of opinion is whether or not the practice costs in urban Michigan or urban Connecticut are really that much different than practice costs in rural areas of those States, not just based on the per square foot cost of rental, but the fact that is often overlooked in rural areas.

There is a tremendous cost of transportation, a tremendous cost of maintenance on what may be in urban areas redundant equipment you may not use because somebody has it right down the street or right down the hall.

There is no such person in the rural areas. In some cases it may actually cost more to hire someone in a rural area with a specific set of skills because there is only one person in that area, and in the urban area there are more people to draw from, and you have more of a competitive market.

The PhysPRC recommendations would narrow the present gap between rural and urban. That certainly goes in the direction that we think is appropriate. We believe the best reading of the data is that there is no prima facie difference of practical costs, rural versus urban. You are raising a different question about regional differences.

I must say that data is not data I have looked at. In other areas of social policy we do not base benefits upon geographic area of reasons. The Social Security annuitant does not get paid a different amount in Miami than they do in Maine. We have some concerns about following a policy that says your benefits will be determined based upon where you choose to reside.

That would be the policy issue that would have some concern about, even looking at geographic differentials, but our testimony deals specifically with the rural/urban differential which we believe is not appropriate.

Mrs. JOHNSON. We may not have geographic differences in how much Social Security we have, but in most Government programs, we have geographic differences in procurement or compensation or some means of taking that into account. I wouldn't want to make the decision that we don't need geographic multipliers without the data to demonstrate that we don't.

Let me follow up on just one other thing. Practically, how would you use patterns of practical research or appropriate care research to control costs?

Dr. BOYLE. Mrs. Johnson, I think there are a number of programs that already exist that would provide models that could be utilized. Review of physicians' practices is one. It has been demonstrated in Maine, for example, that you can change physical behavior given enough information.

Dr. Maynard has indicated earlier in his direct test and then later in response to a question that whether or not someone gets paid for providing a service is an extraordinary incentive for people to alter their behavior if it is truly outside of the norm. It has been indicated also that there are opportunities today to evaluate enormous data bases so that it is possible to identify what constitutes appropriate behavior and compare physician groups with one another or within physician groups.

Mrs. JOHNSON. The long-term implication is that you would use patterns of practice to define reimbursable costs.

Dr. BOYLE. Excuse me. Would you repeat that? I am not sure I understood what you said.

Mrs. JOHNSON. That you would use the practice pattern research to define reimbursable costs. In other words, these are the kinds of things that it is reasonable to do and therefore this is the universe of things for which we would reimburse unless you make a special case for other reimbursables.

Dr. BOYLE. Now, I understand. It would be appropriate to use effectiveness and outcomes research and establish what represents an appropriate form of professional behavior agreed upon by people who are experts in that field to identify those practices, those procedures and those services for which reimbursement will be received unless an exception is made for acceptable reasons.

Chairman STARK. If I could, if the gentlelady would yield, it is the intention of the Chair now to recognize Mr. Donnelly for as long as he cares to take and how quickly he thinks he can make it to the floor.

We have three votes back to back and if there is no objection from the other members, I would then yield to Mr. Donnelly's inquiry, suggest that the panel has concluded, and we would reconvene in a half hour after the three 5-minute votes.

We should be back here about 3:30, and if the gentlelady will allow me, I will recognize Mr. Donnelly for a few minutes.

Mr. DONNELLY. Thank you, Mr. Chairman. Gentleman, I apologize for being late. I just have two questions. One deals with malpractice costs. What percentage of your costs are now due to increasing malpractice premiums?

Dr. BOYLE. That varies tremendously, Mr. Donnelly, all over the country, but I would say in gross costs for people in primary care, family physicians and general internists, whatever, probably varies somewhere from, oh, 6 to as much as 11 percent.

For people who are in other subspecialties within internal medicine, those costs can be very substantial costs. Invasive cardiology, as an example, can be very very high. People in gastroenterology can also be significantly higher so that those costs may be substantially greater for them.

Now for surgical specialists that is a whole new ball game.

Mr. DONNELLY. Dr. Graham.

Dr. GRAHAM. For a family physician in a rural area doing obstetrics, malpractice costs can be in the neighborhood of 15 percent of total costs. That is the high side where you see the combination of a very high malpractice environment and the rural physician who tends to have higher costs and lower revenue.

For a family physician not doing obstetrics those costs will probably vary between 3 to 7 percent, depending on the malpractice environment in which they are.

Mr. **Donnelly**. Doctor.

Dr. **Maynard**. For me personally, it is about 8 percent. Internal medicine primary care is a category one in the State of Massachusetts, but it varies widely, and again this is a different issue from what we are talking about today, but it is a major disincentive.

Mr. **Donnelly**. Well, it is really not a different issue. The second part of my question is: What percentage of malpractice claims are filed by Medicare beneficiaries? I think there is a relationship between your escalating costs and your need for additional payment for services, because much of the increased costs are due to malpractice premiums. But how many claims are made by our Medicare beneficiaries. That is not an issue that has been raised prior to a few weeks ago, but it is an issue that I am going to pursue and make sure that the committee pursues.

I think it takes some study. I am very sensitized to it coming from Massachusetts because we have, you know, an absolute crisis in malpractice insurance, and it has caused the fixed costs of the physician to skyrocket over the course of the last few years.

Having said that, let me ask you a question on the whole issue of assignment. If we establish an adequate reimbursement for physicians, would you people be willing to accept that as full payment for services?

Dr. **Maynard**. I come from your State, Mr. Donnelly, and I would like to emphasize how difficult it has been to practice in the environment of mandatory Medicare assignment in our State.

Mr. **Donnelly**. But isn't the problem, isn't the argument against mandatory assignment legislation that we don't properly and adequately compensate physicians for services? My question is, if we do come forward with a system that provides proper compensation for a service to Medicare beneficiaries, are you willing to accept that as full payment for that service or is the problem beyond that? Is it a philosophical problem that you don't feel either as an individual or as a professional that you ought to be ham strung in terms of what you can charge an individual patient because you can take into effect what the patient's net worth is?

Go ahead, please.

Dr. **Maynard**. We believe it is very proper and appropriate to have a ceiling as far as billing is concerned for patients in moderate or lower income groups, and yes, that payment can best be determined through an appropriate RBRVS system. We think that would be very logical and appropriate, but there are also patients who insist on and demand and would like to pay more for their medical services if possible.

I can cite an example.

Mr. **Donnelly**. Would you like to?

Dr. **Maynard**. In your State, I happen to have seen in Boston magazine last week that two of my patients were displayed as being worth more than $500 million apiece. They are both Medicare patients. They come into my office, and they are embarrassed by seeing that I am paid something that is less than the office costs.

Mr. **Donnelly**. I understand that, but Dr. Graham, let me ask you again——

Dr. **Graham**. No, I understand the question.

Mr. **Donnelly**. If we adequately compensate you, would you accept mandatory assignment or is it a larger issue that you feel we don't have a right to cap fees?

Dr. **Graham**. Recognizing that it is a very well-established Washington rule that one answers hypothetical questions only at one's own risk, if you were to establish a fair reimbursement basis—which is a huge if—we have wrestled with that question. I think that is one of the most difficult issues within our association that we have had to come to grips with because there are strong philosophical differences.

The history of American medicine and what it is based on is individual relationships between the physician and the patient and the suggestion that a Government or a third-party entity can interfere and interpose itself in that relationship is absolutely abhorrent to many of our members.

Mr. **Donnelly**. That is really a problem, isn't it?

Dr. **Graham**. That is a problem for some people, and I think it is a valid philosophic problem. At the same time, going back to the premise of your question, I believe that were a Medicare fee system to be widely perceived as a fair system by practicing physicians, and RVS you need to recognize may not in itself be that.

There is the implication to me that even under an RVS physicians might still be delivering services at a discount, but if, to go back to your hypothesis, it was perceived as a fair system, reimbursing the physician at what they are charged would be for anyone. I believe it is likely the vast majority of our members would not seek to balance bill.

They would indeed view if the fee is fair there is no balance to bill, so I think it goes beyond philosophy. It does get into actuality of what the reimbursement base is. What we have said in commenting on the physician payment of review recommendations to you is that we believe that it is reasonable public policy to discuss on the table that if there is an RVS established which is based on a relative assessment of value and if that is the fee which a physician may bill that we think, A, there are certain categories of patients we have defined that as twice the poverty level or below for whom assignments should be mandatory, if we still use those terms. And, B, that it is reasonable to look at some level above that charge—we have selected 25 percent as the total extra that can be billed——

Mr. **Donnelly**. I am getting my due for coming late to the hearing. I have 4 minutes to go vote. You can outtalk me. That is something that does not happen often in Washington. We will continue this discussion at a later time.

Dr. **Boyle**. Very briefly, Mr. Donnelly.

First of all, when I was in practice, I was perfectly willing to accept what Medicare paid. I never accepted assumption. To me that is a very poor issue. In fact, in my office our billings were about 93 percent, within 93 percent of what Medicare would pay. I think that it is extraordinarily important that one keep in mind Medicare has to be perceived as being fair on both sides of the issue.

I think that it is not at all unreasonable to accept that physicians require what Medicare will pay for patients at certain income levels. On the other hand, it does not seem to be fair for government to insist that I contract under certain terms.

Mr. **Donnelly**. Thank you very much. We will obviously discuss this issue later. The hearing will reconvene at 3:30 p.m.

[Recess.]

Chairman **Stark**. We will continue our hearing with our second panel comprised of the major surgical subspecialties. Dr. Robert Reinecke is the president of the American Academy of Ophthalmology; Newton McCollough III, president of the American Academy of Orthopaedic Surgeons; George G. Lindesmith, president of the Society of Thoracic Surgeons, accompanied by George E. Miller; and H. Logan Holtgrewe, treasurer of the American Urological Association.

Gentlemen, if you would like to present your summary or expansion of testimony in the order in which your name appears on the witness list, I would appreciate it.

Dr. Reinecke, would you like to begin?

STATEMENT OF ROBERT REINECKE, M.D., PRESIDENT, AMERICAN ACADEMY OF OPHTHALMOLOGY

Dr. **Reinecke**. Thank you, Mr. Chairman.

My name is Robert Reinecke, M.D. I am a practicing ophthalmologist in Philadelphia, and the president of the American Academy of Ophthalmology in the United States.

We appreciate this opportunity to address the committee today on short- and long-term Medicare physician payment issues. As you know, we have worked diligently with the Congress, the Health Care Financing Administration, and the Physician Payment Review Commission to convey ophthalmology's goals in providing ethical, quality eye care to our Medicare beneficiaries, while at the same time promoting savings and the most efficient use of Medicare dollars.

Fiscal year 1990 budget proposals: The committee requested that we comment on the Bush administration's proposals regarding this year's Medicare budget. We are extremely concerned that the proposals continue to take a piecemeal approach to cost savings through suggesting yet another round of percentage reductions in a small number of selected Medicare procedures, discriminating against certain physicians and against Medicare beneficiaries who need these particular procedures.

We strongly oppose any further cut in cataract surgery. The cataract surgery fee has been cut more than 25 percent during the past 3 years. It has been subjected to an absolute cap on charges, and related services such as assistants at surgery, and cutting ultrasound tests have been significantly reduced. These represent a total 30- to 40-percent reduction.

This year additional volume restrictions have just been implemented whereby State peer review organizations are pre-certifying every single cataract surgery proposed for Medicare patients. We have opposed this approach, because we do not believe that the current method of PRO preapproval will have any impact on reducing unnecessary utilization. We recommended to the PRO's criteria requiring surgeons to document their pre- and post-operative care arrangements to ensure optimum care for the patient, and we have suggested that HCFA consider the feasibility of random second opinions as a potentially more effective alternative. We believe such an approach would result in additional cost savings.

No other Medicare procedure has been singled out and endured such deep reductions and strict regulatory controls, some of which are still in their early stages and have not been evaluated for their impact. Further across-the-board cuts in cataract surgery fees at this time are unnecessary and unwarranted.

We would also strongly object to the administration's suggested 8 percent across-the-board cut for surgery. From an administrative perspective, it would be virtually impossible to implement, because of the complexity of the CPT coding system, the current methods for determining payment profiles, and the difficulty in developing a workable definition of surgical services. For example, at PhysPRC's request, we are examining the ophthalmology CPT codes in an attempt to provide more information on services connected to surgical procedures. However, this is proving to be an arduous task.

Last week, during earlier hearings by the committee, the academy presented alternatives that we believe would produce Medicare budget savings, while promoting a sound health policy aimed at ethical, quality care.

Global fee for cataract surgery: We believe Congress should direct HCFA to prohibit the unbuilding of the global fee for cataract surgery, and prohibit the use of the modifier when the operating surgeon or a surgeon of similar competence does not provide the postoperative care. Carriers should be instructed not to allow billing by nonphysicians during the postoperative period.

These recommendations would save significant Medicare dollars by preventing duplicate billing during the postoperative period, and by reducing the extra volume of surgeries and postoperative visits generated by unethical referral arrangements. A recent report issued by the inspector general found that Medicare billings doubled when ophthalmologists used optometrists as a significant referral source, and unbundled postoperative care. At the request of the chairman, we have submitted evidence of these arrangements to the subcommittee staff, at the request of the chairman.

These arrangements and potential cost savings have been acknowledged by the Inspector General. We would urge the committee to seek from the Congressional Budget Office an estimate of savings which would accrue from enactment of these recommendations.

Furthermore, we would hope and intend to work with the chairman to ensure that his legislation would prohibit such unethical referral arrangements that often result in either unnecessary or premature cataract surgery.

Limits on nonprimary care services: We would oppose the administration's recommended freeze on nonprimary care service fees for 1990–92. Nonprimary care services include vital followup care performed by generalists, as well as specialists, and are important in the continuum of treatment needed by the majority of senior citizens.

In a related area, we respectfully request that the committee review its list of primary care visit services. The last budget reconciliation act omitted primary eye care visits. We strongly urge the committee to include the following primary eye care office visits in the current list of primary care visit services: CPT codes 92002, 92004, 92012, and 92014. These represent intermediate and comprehensive primary eye examinations for new and established patients. These were probably overlooked due to quirks in the CPT code, as the legislative history does not provide any other explanation.

The academy has adopted a preferred practice pattern defining an adult comprehensive eye examination, which we have provided to the committee, to assist in making this correction.

Harvard Resource-based Relative Value Scale: As published in the New England Journal of Medicine and the Journal of the American Medical Association, the Harvard RBRVS would reduce ophthalmology fees by 40 to 45 percent, making my profession one of the most severely impacted of all, despite the fact that one-half to three-fourths of our time is spent in office visits, not in surgery.

Early in the process, we raised objections to obvious biases and flaws in the Harvard methodology and results. Our economic experts have provided us with detailed analyses of the shortcomings, which we have shared with the Physician Payment Review Commission, many of which others also challenged, and indeed, the PhysPRC staff has attempted to correct or redraft.

Our critique of the Harvard RVS focused on the following points.

The need to correct Dr. Hsiao's practice cost calculations, at least to prevent an overstatement of the RBRVS loss/gain effect that results from excluding revised revenue projections in calculating practice costs. PhysPRC addressed this flaw by adding, rather than multiplying in practice costs.

The inadequate representation of ophthalmological evaluation and management services in the Hsiao study, and the apparent selection of a disproportionate number of relatively uncomplicated office procedures.

The choice of an inappropriately low standard procedure in relation to the other surgical vignettes studied.

The oversimplification of pre- and post-service time/work, based on only three ophthalmological procedures. These three do not represent the range of surgical procedures performed by ophthalmologists, and do not include any evaluation and management services.

As a result of these shortcomings, plus the inadequacies of the sample size for ophthalmology, and questionable statistical manipulations, we believe there are serious flaws in Dr. Hsiao's total work variable for ophthalmology.

These factors also call into question the validity of the cross-linkages, and the flaws of the extrapolation methodology.

Attached to our written statement is a copy of Dr. Hsiao's proposal to attempt to correct the ophthalmology portion of his study.

We are concerned that although PhysPRC has been very open and interested in the medical specialty groups' comments, it does not appear to have corrected some important flaws in the Hsiao study.

Office visits undervalued: Perhaps most frustrating is the fact that ophthalmology's primary eye care office visit fees will be reduced, according to PhysPRC's impact analysis, while other primary care office fees of other medical providers are significantly increased. Our primary care office visits take as much or more time as a general practitioner's, and certainly entail higher costs in our everyday diagnostic equipment.

Specialty differentials: We are concerned that PhysPRC did not acknowledge the differences between specialties in its recommendations. For example, we believe it is more costly to equip an ophthalmologist's office. It is not clear whether PhysPRC's proposed service-specific practice factor will account for these costs.

We are extremely concerned that dropping specialty differentials not only represents a significant departure from current payment and service identification practices, but could lead to an unintended overinflation of the fee schedule if nonphysician practitioners were paid the same.

Geographic variations: We are concerned that PhysPRC's proposed geographic factor only accounts for variations in some of the costs of practice in an area, and does not give necessary and appropriate credit to the variations in cost of living for physicians in different areas.

Research on practice standards: We would not be opposed to an increased emphasis on quality of care research as long as medical specialty groups play a central role.

The academy is initiating many projects along these lines, including: establishment, in 1986, of a code of ethics defining ethical, quality care and treatment of patients; working with the inspector general's office, State peer review organizations, the General Accounting Office and others to identify those ophthalmologists who are not practicing ethical, quality acre; development of preferred practice patterns of care for major ophthalmic services. The first approved by the academy's board described a comprehensive adult eye examination, and care for glaucoma.

In summary, the academy has grave concerns regarding both the Hsiao RBRVS and PhysPRC Medicare fee schedule.

Since we are expecting to reach an agreement with the Harvard team to begin their restudy of ophthalmology, we would view the PPRC's recommendation that the fee schedule be implemented in 1990 as premature. Dr. Hsiao plans to incorporate our restudy into his phase II work on the RVS, and certainly Congress should consider those results before enacting either Dr. Hsiao's or PhysPRC's plans in their current form.

Further, if any form of physician payment reform is enacted, a 4- to 5-year phased implementation would be recommended by our group as opposed to a more speedy implementation.

Recognizing Congress' interest in near-term Medicare budget savings, we strongly urge the committee to adopt our recommendations to prevent the unbundling and duplicate billing of postoperative services following cataract surgery, a direction that would maintain the quality of cataract surgery care, while holding down Federal costs.

Similarly, a modification of the chairman's Medicare referral bill, as we have previously recommended, would probably slow the rate of increase in the volume of questionable or premature cataract surgery and thereby result in additional savings.

Thank you for this opportunity to present our views.

[Attachments to the statement follow:]

QUALITY OF OPHTHALMIC CARE

Comprehensive Adult Eye Evaluation Preferred Practice Pattern

Approved by: Board of Directors
October 12, 1988

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INTRODUCTION

As a service to its members and the public, the American Academy of Ophthalmology is developing a series of guidelines termed *Preferred Practice Patterns,* that identify characteristics and components of *quality eye care.* These guidelines are particularly timely and appropriate as third party payors and government grapple with the need for maintaining quality care in the face of cost-containment, and as traditional attitudes of Academy members are challenged by changing patterns of health care delivery and emerging market forces.

These *Preferred Practice Patterns* are neither minimal nor aspirational; they represent quality eye care commensurate with present knowledge and resources. They are based upon the best available scientific data as interpreted by panels of knowledgeable health professionals. In some instances the data are particularly persuasive (as with results of carefully conducted clinical trials) and provide clear guidance; in other instances the panels had to rely more heavily on their collective judgment and evaluation of available evidence. As better data become available these guidelines will be altered as appropriate.

Preferred Practice Patterns provide guidance to the *pattern* of practice, not to the care of a particular individual. While they should generally meet the needs of most patients, they can not possibly best meet the needs of all patients. Depending upon a host of medical and social variables, it is anticipated that it will be necessary to approach some patients' needs in different ways. The ultimate judgment regarding the propriety of the care of a particular patient must be made by the physician in light of all of the circumstances presented by the patient. Adherence to these *Preferred Practice Patterns* will certainly not ensure a successful outcome in every situation. These *Preferred Practice Patterns* should not be deemed inclusive of all proper methods of care or exclusive of other methods of care reasonably directed to obtaining the best results.

It is the Academy's intention to update all *Preferred Practice Patterns* as new knowledge dictates. To ensure all *Preferred Practice Patterns* are current (and where not, no longer applicable) each is valid for three years from the date of issue unless superseded by a revision.

Approved by: Board of Directors
October 12, 1988

CORE CRITERIA

"Providing quality care is the physician's foremost ethical obligation, and is the basis of public trust in physicians."

AMA Board of Trustees, 1986

"Quality ophthalmic care" is provided in a manner and with the skill that is consistent with the best interests of the patient. This document characterizes the core elements of such care.

The ophthalmologist is first and foremost a physician. As such, the ophthalmologist demonstrates compassion and concern for the individual and utilizes the science and art of medicine to help alleviate patient fear and suffering; strives to develop and maintain clinical skills at the highest feasible level, consistent with the needs of the ophthalmologist's patients, through training and continuing education; evaluates those skills and medical knowledge in relationship to the needs of the patient and responds accordingly; ensures that needy patients receive necessary care directly or through referral to appropriate persons and facilities that will provide such care; and supports activities that promote health and prevent disease and disability.

Ophthalmologists recognize that disease places patients in a disadvantaged, dependent state. Ophthalmologists respect the dignity and integrity of their patients and do not exploit their vulnerability.

Quality ophthalmic care has the following optimal attributes, amongst others:

1. A meaningful partnership relationship between patient and physician is essential to quality care. Ophthalmologists strive to communicate effectively with their patients, listening carefully to their needs and concerns, and in turn educating them about the nature and prognosis of their condition and about proper and appropriate therapeutic modalities so as to ensure their meaningful participation (appropriate to their unique physical, intellectual and emotional state) in decisions affecting their management and care, to improve their motivation and compliance with the agreed upon plan of treatment, and to help alleviate their fears and concerns.

2. The ophthalmologist's best judgment is brought to bear in choosing and timing appropriate diagnostic and therapeutic modalities as well as the frequency of evaluation and follow-up, with due regard to the urgency and nature of the patient's condition and unique needs and desires.

3. The ophthalmologist carries out only those procedures for which he or she is adequately trained, experienced and competent, or when assisted by someone who is, in relation to the urgency of the problem and availability and accessibility of alternative providers.

4. Patients are assured access to, and continuity of, needed and appropriate ophthalmic care:

   - ophthalmologists treat patients with due regard to timeliness, appropriateness and the ability of the practitioner to provide such care.

   - adequate provision is made by the operating ophthalmologist for appropriate pre- and post-operative patient care.

   - provision is made for appropriate ophthalmic care when the patient's ophthalmologist is unavailable, with adequate mechanisms for informing patients of the existence of, and procedures for obtaining, such care.

   - referral of patients to other ophthalmologists and eye care providers is based upon the timeliness and appropriateness of such referral, as determined by the ophthalmologist on the basis of the patient's needs, the competence and qualifications of the person to whom the referral is made, and access and availability.

   - with due regard to the nature of the ocular or other medical or surgical problem the ophthalmologist seeks appropriate consultation; consultants are suggested for their skill, competence, and accessibility; the consultant receives as complete and accurate an accounting of the problem as is necessary to provide efficient and effective advice or intervention, and who in turn responds in an adequate and timely manner.

   - the ophthalmologist maintains complete and accurate medical records.

   - upon appropriate request the ophthalmologist provides a full and accurate rendering of the patient's records in his possession.

   - results of consultations and laboratory tests are reviewed in a timely and effective manner and appropriate actions taken.

- the ophthalmologist, and those who assist in providing care, identify themselves and their profession.
- patients whose conditions fail to respond to treatment and patients for whom further treatment is unavailable are provided with proper professional support, counseling and rehabilitative and social services and referral as appropriate and accessible.

5. Prior to therapeutic or invasive diagnostic procedures the ophthalmologist becomes appropriately conversant with the patient's condition by collecting pertinent historical information and performing relevant preoperative examinations. Additionally, he or she enables the patient to reach a fully informed decision by providing the patient with an accurate and truthful explanation of the diagnosis; the nature, purpose, risks, benefits, and probability of success of the proposed treatment and of each alternative treatment; and the risks and benefits of no treatment.

6. New technology (e.g., drugs, devices, surgical techniques) is adopted in judicious fashion, appropriate to the cost and potential benefit relative to existing alternatives, and to its demonstrated safety and efficacy.

7. Ophthalmologists enhance the quality of care they provide by periodically reviewing and assessing their own personal performance in comparison with established standards, and revising or altering practices and techniques appropriately.

8. Ophthalmic care is improved by communication among colleagues, through appropriate professional channels, of knowledge gained through clinical research and practice. This includes alerting colleagues of instances of unusual or unexpected rates of complications and problems related to new drugs, devices or procedures.

9. Ophthalmic care is provided in suitably staffed and equipped facilities adequate to deal with potential ocular and systemic complications requiring immediate attention.

10. Ophthalmic care is provided in a manner that is cost effective without unacceptably compromising accepted standards of quality.

Approved by: Board of Directors
October 12, 1988

PREFERRED PRACTICE PATTERN

A. *Activity:*

Comprehensive Adult Eye Evaluation

B. *Purpose:*

A comprehensive eye evaluation will detect and diagnose sight, health and life threatening disease.

C. *Indications:*

Adult patient, without complaints, seen for an eye evaluation for the first time or after an extended duration.

D. *Goals:*

1. Determine the optical and health status of the eye, visual system and related structures.
2. Detect and diagnose ocular abnormalities and disease, and factors placing the patient at increased risk of such disease.
3. Establish and document the presence or absence of ocular signs or symptoms of systemic disease.
4. Discuss the nature of the findings and their implications with the patient.
5. Initiate an appropriate response (e.g. further diagnostic tests, referral, and/or treatment when indicated).

E. *Background and Justification:*

1. At least one-fourth of all Americans have optical abnormalities requiring correction for clear distance vision,[1] and a third (80 million) a medical or surgical disease of the eye and visual system.[2-4]

2. Many individuals are unaware of their abnormalities (15% of subjects enrolled in a recent randomized population-based study were found to have significant ocular pathology, many of whom were unaware of it).[5] Even potentially blinding diseases can be altered by appropriate intervention (e.g.):

   Laser treatment at an appropriate time can reduce the risk of blinding diabetic retinopathy by 50% or more[6] and neovascular glaucoma by a clinically meaningful degree, yet one-third or more of known diabetics do not receive appropriate ocular evaluation.[7]

   While there are no randomized, masked controlled clinical data, for ethical and other reasons, long clinical experience and epidemiologic data[3] strongly suggest that reduction of elevated intraocular pressure will reduce the risk of progressive glaucomatous optic nerve damage. The prevalence of glaucomatous nerve damage increases with age, averaging 1% for all subjects over 40, while another 5% are at increased risk of damage and require identification.[3] Unfortunately, chronic simple glaucoma is asymptomatic until irreversible visual loss is extensive.

   Macular degeneration, another major cause of blindness may be asymptomatic while the patient develops subretinal neovascularization which can be blinding.[8,9] If followed and treated with lasers appropriately, the risk of the severest forms of visual loss in such patients can be reduced by 50%.[10]

   Other examples of high risk conditions or diseases include a past history of ocular trauma or the presence of abnormalities of the front of the eye that increase the risk of open angle and angle closure glaucoma, and those of the back of the eye, such as retinal tears and degenerations, that increase the risk of retinal detachment.

   Only a thorough ophthalmologic evaluation will uncover these common conditions, and at the same time less common but extremely serious conditions such as early tumor of the eye, visual system and related structures.

3. A number of prevalent systemic and regional diseases (e.g. diabetes, hypertension, AIDS and other infections, metastatic tumors, central nervous system abnormalities) are often first diagnosed by the appearance of the eye and, or symptoms elicited during a comprehensive ophthalmologic evaluation.

F. *Procedure:*

Listed below are the major components of a comprehensive eye evaluation. Within each are included a series of items particularly relevant to the detection, diagnosis and choice of appropriate therapy for ocular, visual, and systemic disease.

The items listed are not meant to exclude additional elements when appropriate. For example, history taking is an interactive and reactive process. Listed are core, basic areas of inquiry; depending upon the patient's response additional questions, probing, and evaluation may well be indicated.

I. *History:*

In general, a thorough history will include the following items, though the exact composition will necessarily vary with the patient's particular needs.

1. Demographic data: Includes, among others, name, date of birth, sex, race, and occupation.
2. The identity of other pertinent health care providers utilized by the patient.
3. Chief complaint and history of present illness. (While this exercise is oriented towards the asymptomatic patient, there is always some reason why a patient chose to have an examination at this time, and not a year before or a year hence.)
4. Present status of vision: To include a review of the patients' assessments of their own visual status, their visual needs, and any ocular symptomatology they may presently be experiencing.
5. Past history (ocular): Prior eye disease, diagnoses, treatments, medications and concerns.
6. Past history (systemic): allergies, medication use, and pertinent medical problems and hospitalizations.
7. Family history: Poor vision (and cause if known); other pertinent familiar ocular and systemic disease.

II. *Examination:*

The comprehensive examination consists of an evaluation of the physiological functioning and the anatomic status of the eye, visual system and its related structures. In general this will include, but not be limited to, evaluation of the following:

Physiologic function:

1. Visual acuity with present correction (the power of the present correction recorded) at distance, and where appropriate, near.
2. Measurement of best corrected visual acuity (with refraction where indicated).
3. Ocular alignment and motility.
4. Pupil.
5. Intraocular pressure.

Anatomical status:

6. Lids, lashes and lacrimal apparatus, orbit, and other facial features which may be pertinent.
7. Anterior segment: tear film, conjunctiva, sclera, cornea, anterior chamber, iris, lens, posterior chamber.
8. Posterior segment: vitreous, retina (including posterior pole and periphery), uvea, vessels, and optic nerve.

Examination of anterior segment structures will routinely involve gross and biomicroscopic evaluation prior to dilatation. Evaluation of structures situated posterior to the iris will generally require dilatation of the pupil. Posterior segment structures will be routinely examined with an ophthalmoscope.

While it is assumed the ophthalmologist will perform most of the examination, certain aspects of data collection may be conducted by another trained individual under the ophthalmologist's supervision and with his or her review.

III. *Outcome:*

The ophthalmologist considers all aspects of the patient's health status, results of the comprehensive ophthalmologic examination, and social situation in determining an appropriate course of action.

1. ***Normal:***

When evaluation is entirely normal or only involves optical abnormalities requiring a spectacle prescription, the ophthalmologist will reassure the patient and advise him or her with regards to the appropriate interval for re-examination. All patients are advised to return as soon as possible should ocular symptoms or related problems develop.

In the *absence of symptoms or other indications,* patients should generally be seen for a comprehensive examination within the period indicated below, which takes into account the relationship between their age and race and the risk of asymptomatic or otherwise overlooked disease:

65 years or older	every 1–2 years
40–64 years	every 2–4 years
20–39 years	Blacks, because of the high incidence and more aggressive course of glaucoma even in the absence of visual or ocular symptoms, should be seen every 3–5 years. Others can be seen less frequently.

INTERIM EXAMINATIONS MAY BE EXPECTED TO BE PERFORMED FOR DISCREET PURPOSES, ROUTINE REFRACTIONS, AND PATIENT REASSURANCE AT MORE FREQUENT INTERVALS.

2. ***Abnormal:***

When findings are significantly at variance with normal, the response of the ophthalmologist will depend upon those findings:

a. For ophthalmic abnormalities prescribe glasses or other devices or medications, perform surgical or other procedures, or arrange for additional evaluation and history as appropriate.

b. For nonophthalmic abnormalities arrange for further nonophthalmic (e.g. systemic) testing and/or referral as appropriate.

c. Convey the significance of the findings and need for further evaluation, testing, and/or treatment to the patient.

The vast majority of patients with abnormal signs and symptoms can be diagnosed and treated appropriately in the course of a comprehensive ophthalmologic medical evaluation. *ADDITIONAL DETAILS OF THAT EVALUATION AND RECOMMENDATIONS FOR APPROPRIATE TREATMENT AND FOLLOWUP WILL NECESSARILY VARY WITH THE ABNORMALITIES AND DISEASES IDENTIFIED.*

Approved by: Board of Directors
October 12, 1988

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JUSTIFICATIONS

1. Quality of care is an urgent concern in the face of threats to the quality in the present climate of cost containment, and the rapid disappearance of traditional peer review and educational mechanisms, such as pre- and post-operative hospital rounds, as the performance of eye surgery shifts from inpatient to ambulatory settings and other modifications of practice patterns.

2. By virtue of training and experience ophthalmologists are uniquely competent to develop *Preferred Practice Patterns* of quality ophthalmic care, and have an obligation to the public and our patients to do so.

3. Such *Preferred Practice Patterns* are needed to:
   - a. ensure that changes in health care delivery do not unacceptably compromise quality.
   - b. maintain and, where necessary, raise the quality of ophthalmic practice, by providing criteria against which we can each measure our own performance.
   - c. help to identify individual shortcomings and assist ophthalmologists in improving their performance.
   - d. provide appropriate guidance to residents, fellows and others in training.

4. Quality care standards, quality assurance and quality assessment are already with us. Some agencies (HCFA, third party payors, industry) seek to measure quality by application of quantitative standards. It is crucial that a set of criteria, embodying the highest principles and knowledge of the healing arts, be put forth to serve as the single overriding *Preferred Practice Pattern* for measuring quality that can serve varied needs and interests, and protect the public and our patients.

5. *Preferred Practice Patterns* provide a basis for assessment and self regulation, which the profession professes and which the public expects.

6. *Preferred Practice Patterns* provide a means of educating the public. An informed public is more likely to appreciate and support efforts and demands for quality care.

7. *Preferred Practice Patterns* would strengthen ties between ophthalmology and the rest of medicine, and reverse the increasing isolation of ophthalmic practice.

Approved by: Board of Directors
October 12, 1988

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HARVARD UNIVERSITY
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WILLIAM C. HSIAO
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March 16, 1989

Dr. Robert Reinecke
President
American Academy of Ophthalmology
655 Beach Street
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San Francisco, Calif. 94120-7424

Dear Dr. Reinecke:

I was pleased to have a chance to talk with you on the telephone recently. I received two letters from Dr. Spivey dated November 3 and January 19. These letters raised several questions about the resource-based relative value study (RBRVS) and its results. My colleagues and I have given careful review to the points raised by the American Academy of Ophthalmology and we had some discussions internally about the issued raised in these letters.

I am writing to you to propose a restudy of ophthalmological services to resolve your concerns. We have learned a great deal about ophthalmological services from the first phase of our study. We believe our method, data collection had produced credible results, but that they can be improved for ophthalmology. For example, we learned that some ophthalmological services are highly specialized; not all ophthalmologists perform these services. Therefore, it is desirable for us to resurvey your specialty to obtain and use only the rating of work from those respondents who are performing these procedures with some frequency. Second, because your specialty has several subspecialties, we should increase our sample size to insure that we obtain a large number of informed responses for every surveyed service. Finally, the relative values we calculated from the extrapolation method need improvement because we did not have a clear definition of pre- and post-services for your specialty.

For the reasons cited above, we propose to restudy ophthalmological services and coordinate this restudy with the second phase of the RBRVS study. We propose to apply any improved methods from Phase II in your specialty. In addition, we will undertake the following specific research tasks:

-- increase the sample size in a resurvey of ophthalmologists so we have at least 150 respondents. We will also aim to obtain responses from two-thirds or more of the ophthalmologists surveyed.

-- incorporate questions in the resurvey to ascertain how frequently the respondent performs the procedure that he/she evaluates.

-- reexamine the pre- and post-services for ophthalmological procedures. We will also be asking for your assistance to get an empirical assessment on how many post-hospital discharge visits are included in the current billing of ophthalmological procedures.

-- design a survey instrument to survey only the total work of the procedures (i.e., we will not obtain the rating of the dimensions of the work). Hence, we can cover more procedures performed by ophthalmologists and obtain more comprehensive information on pre- and post-service work in your specialty.

-- reexamine the procedure chosen as the reference standard that we had used in the first place. The reference standard was chosen with care by the Technical Consultant Panelists; nevertheless, we will reevaluate to see whether some improvement can be made.

-- establish a cross-specialty panel to improve the cross-specialty links for ophthalmology. We will also develop methods to validate these links. In this area, we will endeavor to select ophthalmological procedures that can serve as links to other surgical procedures.

-- collect the most up-to-date information on practice costs for your specialty and insure that they are accurate and reliable. We may ask your specialty to assist us in obtaining the most accurate and most up-to-date information.

-- improve the extrapolation method by obtaining the latest charge data and editing the data for accuracy before they are used for extrapolation. Moreover, we will insure that the services included in the global billing are accurately reflected in any extrapolation method.

-- enlarge the Technical Consultant Group (TCG) for ophthalmology to four members. The selection of TCG panelists will follow the same procedure as in Phase I by obtaining nominations from AMA in establishing the TCG. The financing of TCG panelists will follow what was done in Phase I of the RBRVS study.

-- organize a Validation Panel composed of 10 - 12 ophthalmologists. The 12 members will include the four TCG panelists. The function of this panel is to review and validate the extrapolated relative values and to carry on a parallel group process to validate the national survey results. We expect this panel will meet twice in Boston, with other work being done by mail. Harvard will cover the local expenses, but the specialty societies will pay the air travel.

The estimated budget for a restudy of ophthalmology is $210,000. The budget needs to cover:

1. The employment of a senior physician (part-time) who will direct a restudy of ophthalmology

2. A senior research analyst.

3. Survey of a larger sample (250) ophthalmologists.

4. Consultation and meeting with TCG panelists.

5. Consultation and meeting with the Validation Panel.

6. Data collection, data analysis, and derivation of preliminary and final results.

7. Overhead cost to Harvard University.

I am looking forward to working with your Academy to improve the results for ophthalmological services. I am confident it can be done. Please call me if you have any question. I look forward to your response to this letter.

Sincerely,

William Hsiao

William Hsiao

cc: Dr. Edmund Becker
Dr. Mark Segal, AMA

Chairman STARK. Dr. McCollough.

STATEMENT OF NEWTON C. McCOLLOUGH III, M.D., PRESIDENT, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS, AND DIRECTOR OF MEDICAL SERVICES FOR SHRINERS' HOSPITALS FOR CRIPPLED CHILDREN, TAMPA, FL

Dr. McCOLLOUGH. Mr. Chairman and members of the subcommittee, I am Newton McCollough, president of the American Academy of Orthopaedic Surgeons and director of medical services for Shriners' Hospitals for Crippled Children, and a professor of orthopedic surgery at the University of South Florida.

The American Academy of Orthopaedic Surgeons appreciates the opportunity to comment on various physician reimbursement issues before Congress.

The academy shares the concerns of the public and the Federal Government about the rising costs of health care in America, and wants to participate actively in developing effective cost-containment strategies. However, these strategies must be developed and implemented in a way which does not compromise the quality of health care.

In our testimony today, we wish to discuss the following issues: One, the proposed resource-based relative value scale; two, the implementation period for a new Medicare fee schedule; three, professional liability expenses in relation to medical practice costs and physician fees; four, physician acceptance of Medicare assignment for low-income families; five, improving the standardization of coding and billing practices; six, the development and implementation of Medicare expenditure targets; and seven, efforts to identify and eliminate ineffective and inappropriate medical practices.

The proposed resource-based relative value scale [RBRVS]: We believe that the proposed RBRVS seriously misrepresents the value of orthopedic services relative to other medical services. Furthermore, the RBRVS will not address the concerns of the medical profession and the Federal Government about increasing health care costs.

In addition to having serious methodological flaws, the RBRVS fails to consider important factors such as the severity and complexity of the patient's condition and the benefit/outcome—value—which the service provides to the patient. The Medicare fee schedule should be based on a substantially revised relative value scale, based on more accurately calculated resource costs, blended with historical fee data to provide an index of value.

Medicine and surgery are not industrial/production line activities. The art of medicine and the skill required to perform a service are not easily quantified as resources. The proposed RBRVS would shift billions of dollars from surgical care, where curative and restorative outcomes are clear, in order to increase the compensation for millions of encounters and services where volume constraints are not established by current methods and where the skills employed and patient benefits to be obtained are much more difficult to document.

We believe that the RBRVS is flawed in two major ways. First, the methodology for calculating the resource inputs has serious shortcomings. Revisions are required, including: pre- and post-service time estimates have methodological weaknesses and need further study.

Cross-specialty links for orthopedics often were not as successful as for other specialties; they need to be reexamined and possibly broadened.

The vignettes used in orthopedics may not be representative of the full range of services provided by the specialty and should be reexamined and revised.

The extrapolation methodology used to project the surveyed services to nonsurveyed services produced mixed results as seen in the American Medical Association data and the Harvard study data, and must be carefully analyzed.

A second major flaw is that basing the relative value scale strictly on resource inputs overlooks many important factors contributing to the value of a given service, such as its value to the patient or the quality of the service provided. Recognizing that these factors are not yet sufficiently developed to use in a fee schedule, we support a blended relative value scale, based on an improved RBRVS together with existing physician charges, used as a rough approximation of market demand considerations.

The implementation period for a new Medicare fee schedule: We urge a gradual implementation of the new Medicare fee schedule. The 2-year implementation period proposed by the Physician Payment Review Commission [PhysPRC] is not long enough to accomplish the necessary revisions or to accommodate the serious impact on many orthopedic practices that will result if we are subjected to payment cuts of up to 72 percent for some procedures.

The academy has recently reviewed a procedure-by-procedure description of the impact of the proposed RBRVS on orthopedics. The impact is staggering, with reduced payments ranging from 30–72 percent for many common orthopedic procedures. This cost shifting could have a significant impact on our ability to treat the uninsured patients who need and deserve attention. Our recent practice survey indicates that over 70 percent of orthopedic surgeons regularly provide care for patients from whom they neither expect nor receive compensation.

In order to avoid a catastrophic impact on the organization and viability of thousands of orthopaedic practices, their employees, and the availability of community services, we recommend a much longer phase-in period than the PhysPRC's 2-year period. A gradual implementation period will permit necessary practice reorientation and staffing adjustments.

Professional liability expenses in relation to medical practice costs and physician fees: We believe that any new Medicare fee schedule should treat professional liability expenses as a separate item when determining practice costs as recommended by the PhysPRC, recognizing regional and specialty variations and the need for frequent updating. Federal initiatives to resolve the professional liability problem could result in substantial savings for Medicare.

Giving the volatility of the professional liability situation, we believe that any new fee structure must be extremely sensitive to the impact of professional liability insurance premiums on practice costs and physician fees. Expenses vary widely by geographic area, by specialty, and from year to year.

Physician acceptance of Medicare assignment for low-income families: The academy supports the concept of physician acceptance of assignment for low-income families. Over 53 percent of orthopedic surgeons now participate in the Medicare Program, and 91 percent of nonparticipating orthopedists accept assignment on a case-by-case basis.

Like Congress, the academy has a real concern for needy elderly patients and believes that the profession should express its willingness to accept assignment for patients below set income level as we orthopedists are already doing.

Improving the standardization of coding and billing practices: We support improved standardization of coding and billing practices, and we are working on the methodology and implementation of the PPRC's uniform global fee definition for surgery.

Because individual medicare carriers have different coding and billing policies, wide inconsistencies exist in coding and billing practices. We believe uniform policies could eventually help reduce Medicare expenditures, as well as the likelihood of abuse. To further these objectives, we also believe that the uniform global fee concept should be expanded to include procedures performed by nonsurgical specialties as well.

The development and implementation of Medicare expenditure targets: The academy cannot support the concept of expenditure targets at this time. We believe that extended and careful study of the concept needs to be undertaken to explore the potential impact on patient care and access and to access whether sufficient data is available to establish targets. If expenditure targets are implemented in the future, separate targets should be used for surgical services as distinct from other services.

Efforts to identify and eliminate ineffective and inappropriate medical practices: An alternative to expenditure targets as a way of controlling the volume of Medicare services is to begin identifying and eliminating ineffective and inappropriate medical practices. While methods to do this are in their infancy, many fledgling projects are under way. These projects, including practice guidelines, small-area variation studies, outcome studies, and technology assessment, would benefit from vigorous support by the Federal Government and the private sector. We see this as the most rational approach to dealing with the volume of services issue from the provider standpoint.

Another approach to address burgeoning health care costs is to begin efforts to moderate the volume of services being demanded by the public. To continually restrict resources available to hospitals and providers without moderating demand for services will ultimately lead to a destruction of the finest health care delivery system in the world. Difficult as it may be, you must exert the leadership in addressing the public and its demand for ever-increasing benefits coupled with its unwillingness to pay the reasonable cost of the services it desires.

Top 36 Medicare expenditures: One final point, Mr. Chairman, we recently reviewed 1987 Health Care Finance Administration [HCFA] data on allowed services and allowed charges—see attachment. Of the top 36 most costly services, 6, totaling $2.9 billion for 120.4 million units of service, were for followup office or hospital visits designated as limited, brief, or intermediate. These are the same areas targeted for substantial increases without corresponding volume considerations.

We believe this large volume of services and expenditures should be evaluated for content, need and effectiveness. The Congress, the administration, and medicine must develop mechanisms to determine if the Medicare patient is receiving a health benefit equal to the public dollar spent.

We believe that the Congress must ask what truly makes a difference in longevity and quality of life for our senior citizens. A timely evaluation of Medicare services is essential to determine if all of the billions of dollars being spent are for services and procedures of equal scientific value. The academy stands ready to assist in this type of endeavor.

We appreciate the opportunity to express our view on these physician reimbursement issues, and we look forward to continuing to work with you on these and other vital health care concerns.

Chairman STARK. Thank you, Dr. McCollough.

[An attachment to the statement follows:]

ATTACHMENT

MEDICARE EXPENDITURES FOR 36 MOST FREQUENT PRACTITIONER SERVICES

Procedure Code	Description	Allowed Services	Allowed Charges
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or phacoemulsification technique	1,030,410	$1,505,453,494
90060	Office Medical Service, new patient; intermediate service	40,956,607	$1,034,712,140
90260	Subsequent Hospital Care each day; intermediate services	29,772,656	$ 878,984,597
90050	Office Medical Service, established patient; limited service	42,205,886	$ 858,929,877
90250	Subsequent hospital care, each day; limited services	23,514,348	$ 604,370,681
90620	Initial consultation; comprehensive	4,929,576	$ 447,901,822
90220	Comprehensive history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records	5,672,370	$ 437,393,921
93000	Electrocardiogram, routine EGB with at least 12 leads; with interpretation and report	9,610,604	$ 329,627,435
71020	Radiologic examination, chest, two views, frontal and lateral;	14,641,479	$ 318,617,533
52601	Transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal ureth rotomy are included)	255,471	$ 287,144,256
90070	Office Medical Service, established patient; extended service	8,615,177	$ 283,206,862
90270	Subsequent hospital services, each day; extended services	6,902,831	$ 267,586,089
90040	Office medical service, established patient; brief service	13,042,378	$ 222,178,650
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	16,505,729	$ 205,086,593
90080	Office medical service, established patient; comprehensive service	3,972,181	$ 190,176,015
90020	Office medical service, new patient; comprehensive	3,085,[illegible]3	$ 172,982,180

MEDICARE EXPENDITURES FOR 36 MOST FREQUENT PRACTITIONER SERVICES

Procedure Code	Description	Allowed Services	Allowed Charges
33512	Coronary artery bypass, autogenous graft, (eg, saphenous vein or internal mammary artery); three coronary grafts	62,762	$ 167,378,443
27130	Arthroplasty,acetabular and proximal femoral prosthetic replacement (total hip replacement)	92,100	$ 166,130,169
27447	Medial and lateral compartments with or without patella resurfacing (total knee replacement)	96,236	$ 164,982,258
71010	Radiologic examination, chest; single view, frontal	11,837,278	$ 162,455,025
90240	Subsequent hospital care each day; brief services	8,019,813	$161,632,653
92014	comprehensive, established patient, one or more visits	3,849,185	$151,264,081
90630	Initial consultation; complex	1,245,577	$ 149,800,117
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; complex diagnostic	490,566	$ 148,898,512
33513	Coronary artery bypass, four coronary grafts	53,010	$ 148,857,926
93547	Combined left heart catheterization, selective coronary angiography, one or more coronary arteries and selective left ventricular angiography	205,079	$ 140,414,231
45378	Colonoscopy,fiberoptic, beyond splenic flexure; diagnostic procedure	328,647	$ 136,970,201
80019	Pathology and Laboratory, 19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	7,751,248	$ 135,974,256
66821	Anterior segment -- lens laser surgery (eg, YAG laser)	268,182	$ 129,736,192
45385	Endoscopy: for removal of polypoid lesion	190,565	$ 121,743,259
66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)	87,340	$ 120,975,983
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	3,899,650	$ 116,673,174

MEDICARE EXPENDITURES FOR 36 MOST FREQUENT PRACTITIONER SERVICES

Procedure Code	Description	Allowed Services	Allowed Charges
27244	Open treatment of closed or open intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture, with internal fixation	114,964	$ 116,213,249
90215	Intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records	1,817,042	$ 109,646,446
99173	Intermediate examination, evaluation and/or treatment, same or new illness	2,210,031	$ 106,790,712
90280	Subsequent hospital care; comprehensive services	2,513,618	$ 106,284,272

Chairman STARK. Dr. Lindesmith.

STATEMENT OF GEORGE G. LINDESMITH, M.D., PRESIDENT, THE SOCIETY OF THORACIC SURGEONS, ACCOMPANIED BY GEORGE E. MILLER, JR., M.D., BOTH ALSO REPRESENTING THE AMERICAN ASSOCIATION FOR THORACIC SURGERY, THE SOUTHERN THORACIC SURGICAL ASSOCIATION, AND THE WESTERN THORACIC SURGICAL SOCIETY

Dr. LINDESMITH. Thank you, Mr. Chairman.

Mr. Chairman, I am George Lindesmith. I am president of the Society of Thoracic Surgeons. With me today is Dr. George Miller. We represent the four major cardiothoracic organizations in this country.

We appreciate the opportunity to share our thoughts with you. The problem, as we see it, is a need to moderate the escalation of spending for physicians' services to our Medicare patients. We understand the necessity of making these expenditures more quantifiable and predictable. We believe that efforts to accomplish these goals must not include the risks of limiting either access to care or quality of care for our patients.

First, we wish to comment on the Harvard/AMA RBRVS. Speaking for our specialty, the Harvard group has developed a set of values that are so incorrect as to be totally useless.

We believe that the flaws in the Harvard study are both conceptual and technical. Our written testimony describes these. They are an integral part of Harvard's determination of total work. This is important because any fee schedule that relies on Harvard's total work will inherit all of its flaws.

Recently, PhysPRC has discussed with us the inaccuracy of the Harvard relative values for our specialty. We agree with the PhysPRC's plan to use a consensus panel to correct these values.

Second, we want to comment on the administration's budget proposals. They would eliminate the annual MEI update for surgeons. It assumes surgical fees are too high, but we do not believe this is supported by fact. The few analyses that exist disregard the surgical bundle concept.

Another proposal would further cut fees for the same perennial list of overpriced procedures. Thoracic surgeons charge one fee using one CPT-4 code for a coronary bypass which includes all of the supporting services. We analyzed these costs individually using the proposed RBRVS unbundled method, and found that it resulted in a cost that was more than 2½ times the RBRVS for the bypass procedures. If the bypass bundle is considered in this light, the procedure is underpriced.

We recognize the Government's need to achieve immediate cost reductions. However, rather than arbitrarily cutting nonprimary care services and making additional cuts in the perennial list of overpriced procedures, we believe it would be more equitable to achieve an equivalent cost savings this year by reducing the MEI for all physicians.

From our perspective, a policy is needed that addresses in a constructive way the primary cause of runaway costs: That is volume. A policy is needed that can control the inappropriate volume of services being received per patient. A responsible policy is needed that preserves easy access to and high quality of care for our patients.

One, we have consistently stated that these policies can best be implemented by use of guidelines for treatment and standards of care developed by experienced physicians in each specialty. These guidelines and standards, when complemented by effective monitoring, would control volume to that which is appropriate for high-quality health care.

Two, we recommend the elimination of inappropriate variations of medical fees as now exist throughout the country.

Three, since surgical and nonsurgical fees have been derived differently in the past, it would be disruptive to bundle primary care or to unbundle surgical services. For this reason, we support a separate surgical fee schedule based on the bundling concept.

Four, we support the continued development of a uniform, updated coding system, taking into account the bundling concept.

Five, we have concerns that expenditure caps will limit access to and quality of care as it has in Canada.

Six, the American College of Surgeons' proposal addresses most of our concerns in an effective manner. We recommend the continuing development of this plan and look forward to participating in this process.

Mr. Chairman, we recognize and respect the opinions of our colleagues from whom you have heard or will hear. I am sure we are all united in our desire to effectively maintain access to quality care for our patients with responsible Federal cost control. Our organizations stand ready to work with your committee as you address these issues.

Chairman STARK. Thank you, Dr. Lindesmith.

[The statement of Dr. Lindesmith follows:]

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
HEALTH SUBCOMMITTEE

Hearing, April 17, 1989

Testimony of George G. Lindesmith, M.D. and George E. Miller, Jr., M.D.

Representing:

THE AMERICAN ASSOCIATION FOR THORACIC SURGERY
THE SOCIETY OF THORACIC SURGEONS
THE SOUTHERN THORACIC SURGICAL ASSOCIATION, and
THE WESTERN THORACIC SURGICAL SOCIETY

Mr. Chairman, I am George Lindesmith, President of The Society of Thoracic Surgeons. I also am the authorized representative of the American Association for Thoracic Surgery, the Southern Thoracic Surgical Association, and the Western Thoracic Surgical Association. With me today is Dr. George Miller, who is chairman of a committee representing these four major cardiothoracic organizations. This committee was formed to evaluate proposed changes in the physician reimbursement system for our Medicare patients. We represent almost all cardiothoracic surgeons in this country.

We appreciate the opportunity to share our thoughts with you. The problem, as we see it, is a need to moderate the escalation of spending for physicians' services to our Medicare patients. It is obvious that the number of Medicare beneficiaries is increasing. This will require increasing expenditures even at a constant cost per patient. We understand the necessity of making these expenditures more quantifiable and predictable. We also believe that efforts to accomplish these goals must not include the risks of limiting either access to care or quality of care for our patients. We recognize the importance of this problem and are here in the spirit of helping with its solution.

First, we want to comment on the Harvard Resource-Based Relative Value Scale Study. In January 1989 our representative to the Harvard Resource-Based Relative Value Scale study received the initial results of its work in defining intra-specialty relative values for cardiothoracic surgery (the comparison of relative values of procedures within our specialty, one with the other). Our representative was so astounded at the inaccuracy of these values that he asked our Committee to review his perception. The Committee found that over 50 percent of these values were so inaccurate that the scale could not be salvaged. The only way that a reasonable scale could be developed would be to throw this out and begin again.

I will mention two examples of these errors in Harvard's set of cardiothoracic intra-specialty values. First, they found simple removal of the pericardium to have the highest relative value, whereas in reality it should fall well below the lower one-half of our procedure values. There are a great many other procedures that we perform that require more time and work. Second, since esophageal resection began, it has been common knowledge that there is more work involved in removing the upper third of the esophagus than the lower third, and yet the Harvard group determined the opposite to be the case. The Harvard/AMA scale is replete with such errors in its determination of our intra-specialty relativity.

The immense importance of these errors cannot be overstated because these values are the end result of the Harvard process, which included: (1) national survey, (2) interpretation of relative work for procedures within our specialty, and (3) their process of extrapolation from the values of 22 core procedures obtained by the national survey to the entire spectrum of procedures done in our specialty.

It is important to note that these values should be the easiest to determine correctly. Furthermore, if these intra-specialty values are so incorrect, how can the more difficult to derive cross-specialty values be anything but less correct?

Why have they failed to develop a reasonable intra-specialty comparison for cardiothoracic surgery?

We believe that the flaws in the Harvard study are both conceptual and technical. Conceptually, they perceived that the marketplace for physician services has not been functioning and that, consequently, payments for individual services are distorted and that there is an inequitable distribution of payments between surgeons and non-surgeons. The Harvard study has not considered that, historically, surgeons and non-surgeons have developed totally different systems for valuing their services. Surgeons, together with their patients, have developed bundled values for procedures, which includes all of those facets of patient care related to the procedure. Non-surgeons have historically unbundled the values of their services. These two systems are significantly different. An attempt to force them together quickly will produce such distortion that an unworkable end result is predictable.

We have studied the technical aspects of the Harvard/AMA RBRVS as it relates to cardiothoracic surgery and have found fundamental flaws at each step of the process.

1. National Survey. In Harvard's national survey of our specialty, it may well be that most of the respondents did not perform the operation surveyed. Cardiothoracic surgeons do not comprise a homogeneous group: one group performs general thoracic surgery only (these surgeons basically operate on the chest and its contents with the exception of the heart), they may or may not do peripheral vascular surgery. A second group performs cardiac surgery only. A third performs various combinations of the aforementioned.

A. The Harvard study, by design, selected interviewees from a list into which 50 percent fell in the first group and 50 percent fell into the last two groups. From our National Manpower Survey, we know that fully 30 percent of the third group do not perform cardiac surgery. Thus, it is probable that most of the respondents in the national survey do not actually perform cardiac surgery and, to a lesser extent, this would hold true for general thoracic procedures.

This fact is important because of the fast changing techniques and patient complexities in our specialty, especially cardiac surgery. If one is not currently performing the procedure, one cannot give proper answers. Accordingly, we believe the corresponding data and conclusions were flawed.

B. Representative clinical vignettes used in the survey were less than optimal. The use of a single chamber pacemaker as the standard to compare with other procedures in our specialty for magnitude estimation is not proper. Its level of intensity is quite low and does not relate easily with most of our other procedures. The magnitude difference is so great between this and the majority of our procedures that a significant error should be expected. Our most common operation -- that of coronary artery bypass using the internal mammary artery as a bypass conduit -- was ignored. The method of questioning regarding the vignettes, as well as the 30-minute survey time limit for questioning on 22 procedures, led to an incorrect evaluation of time intensity relationships. The questions required answers from an unbundled perspective, whereas the cardiothoracic surgeon characteristically thinks of these procedures from a bundled perspective. It is difficult for the surgeon to adjust his thinking to respond appropriately, given the instructions and the time constraints of the interviews.

2. Time intensity relationships within cardiothoracic surgery. As a result of the lack of understanding of our specialty and the resultant flawed survey, the study's interpretation of time intensity relationships of intra-procedure and post-procedure periods improperly described what actually occurs in our specialty. Intra-procedure or operative time was not properly constructed. Our patients have diseased cardiovascular systems, making them especially vulnerable to problems in the pre-incisional period (that time from insertion of monitoring lines and induction of anesthesia until the incision is made). This time is termed "wait time" by the Harvard group, and is valued at one-half the intensity of pre-service time. In the pre-incision time, not infrequently emergency entrance into the chest is required prior to full preparation for surgery -- sometimes even while the patient is undergoing cardiopulmonary

resuscitation. Pre-service time is very different. In pre-service time the surgeon takes a history, talks to the family, and calls the referring physician. Relating pre-incision time to pre-service time is fundamentally incorrect. The intensity level of pre-service time is far lower than pre-incisional.

When we saw the Harvard study's reported operative time for triple coronary artery bypass taking 202 minutes, this seemed inconsistent with our experience. We surveyed our membership and obtained data from their operating room records, showing that for a triple coronary artery bypass our time was 257 minutes.[1] If the internal mammary was used (as it should be because of better long-term results, e.g. less need for costly operation in the future), our time was 283 minutes, or 40 percent longer.

In regard to post-operative time, we have a very high intensity period in the immediate post-operative phase of recovery. This is called the "post-operative stabilization period", which always lasts several hours and sometimes up to 24 hours. This is primarily due to bleeding and its complications, but also arrhythmias, pulmonary insufficiency, and other critical problems tend to occur during this period. The intensity value for this time must be near that of intra-operative. Additionally, in the post-operative stabilization period, 5 percent of cases must be returned urgently to the operating room.

These two periods, pre-incision operative time and immediate post-operative stabilization time, are periods of high intensity not routinely experienced by other surgical specialties. They have been completely overlooked in the Harvard evaluation.

3. Extrapolation. In an attempt to accurately define this problem, we have looked at the values obtained as a result of the national survey separately from the values obtained as a result of the extrapolation process. We have found the core procedures resulting from the national survey to be significantly flawed, but the extrapolation process produced even more significant errors in the extrapolated values. We have been told by Dr. Hsiao's associates that they recognize the serious error in their method of extrapolation from the core 22 procedures to the rest of our specialty.

We have not yet seen how these extrapolated values compare with those in other specialties (cross-specialty comparison), but we must believe that the cross-specialty relationships will be in even more disarray.

Speaking for our specialty, the Harvard group has developed a set of values that are so incorrect as to be totally useless. Dr. Hsiao and his group have been studying this problem and revising their methods for over ten years. Their current system remains seriously flawed.

These conceptual and technical flaws are integral parts of Harvard's determination of "Total Work". This is important because any fee schedule that relies on Harvard's "Total Work" will carry forward all of the Harvard flaws.

Recently, PPRC has discussed with us the inaccuracy of the Harvard relative values for our specialty. PPRC has agreed to use a consensus panel to establish proper values.

It would be derelict of us not to further impress upon you that to use this scale as a method of payment for Medicare patients undergoing cardiothoracic surgery would cause such chaos, that the failures exhibited in the Commonwealth of Massachusetts at the first trial of this system a few years ago would be repeated nationwide. Even the Harvard group is offering to restudy this subject.

Second, we want to comment on the Administration's budget proposal that would eliminate the annual Medicare Economic Index (MEI) update for non-primary care physicians over the next three years. In other words, this proposal would increase primary-care fees while freezing surgical fees. It is clearly based

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1/ Survey forms to 2,353 actively practicing domestic members of the Society of Thoracic Surgeons, 608 responses were tabulated. A response from 325 was needed for statistical representation of the entire STS membership.

on the notion that surgical fees are too high while primary-care fees are acceptable. We do not believe this assumption is supported by fact.

This proposal singles out non-primary care physicians for major cuts. After three years, surgical fees would be effectively cut by 14 percent with 5 percent annual MEIs, and the effective cut would be 25 percent with 10 percent MEIs. Thus, this proposal is tantamount to an implementation of the Harvard results without regard to its conceptual and technical inaccuracies.

We are aware of comparisons performed by the Harvard RBRVS project staff currently and over the last several years in which they juxtaposed (a) the relationships among Medicare payments assigned to selected CPT-4 codes with (b) the relationships among the then-current version of the Harvard RBRVs for the same CPT-4 codes. But those analyses are not proper because they disregard the fact that surgical fees represent a bundle of services while primary-care fees do not. They do not compare apples and apples. Moreover, the RBRVs used in those comparisons are flawed, for the reasons we stated earlier in this testimony.

Thoracic surgeons charge one fee for bypass surgery, which they assign entirely to the primary CPT-4 code. That one fee encompasses all the services provided from the first office visit, through the procedure itself and the hospital stay, culminating in the final post-surgical office visit. We identified each of the services, their CPT-4 codes, and the number of times they are usually performed by a thoracic surgeon while treating a typical bypass patient over several months. Even though we believe the Harvard RBRVs are erroneous, we added up all the RBRVs for that set of services, and the conclusion was dramatic--more than two-and-a-half times the 1988 Harvard RBRV for the triple bypass procedure itself. This is consistent with our practice experience. We are prepared to meet with the Committee's staff to review our analysis in detail.

We understand the Government's need to reduce Medicare Part B costs. If savings must be obtained through a reduction in the MEI, then the reduction should be the same for all physician services.

Third, we want to comment on another Administration budget proposal that would reduce fees for "over-priced procedures." We strenuously object to use of the same list of "over-priced" procedures year after year. Moreover, that list was established without considering the bundling of services, as we described above.

We recognize the Government's need to achieve immediate cost reductions; however, for the reasons noted, the Government's list of "over-priced" procedures used in the past years is wrong and it seems unlikely that a proper list could be constructed in the next few months that would incorporate all the bundles now in use. Thus, rather than making additional cuts to the same list of "over-priced" procedures, it would be more equitable for the Committee to seek an equivalent cost savings by reducing the MEI equally for all physicians.

Recommendations:

From our perspective, a policy is needed that addresses in a constructive way the primary cause of runaway costs -- volume. A policy is needed for the longer term that can control the inappropriate volume of patients receiving services and, more importantly, the inappropriate volume of services being received by a patient. A responsible policy is needed that preserves easy access to and high quality of care for our patients.

1. We have consistently stated that these policies can best be implemented by use of guidelines for treatment and standards of care developed by experienced physicians in each specialty. In our specialty, some of this work is in progress. These guidelines and standards, when complemented by effective monitoring, would control volume to that which is appropriate for high quality health care.

2. We recommend the elimination of inappropriate variations of medical fees as now exist throughout the country.

3. Since surgical and non-surgical fees have been derived differently in the past, it would be disruptive to bundle primary care or unbundle surgical services. For this reason we support a separate surgical fee schedule based on the bundle concept. PPRC and our organization have developed separately a similar generic surgical bundle.

4. Fears of Federal Trade Commission antitrust violations has hampered us from being properly active in the above three areas. We would request your help in obtaining the necessary protection so we could develop these concepts in a responsible way.

5. We support the continued development of a uniform, updated coding system, taking into account the bundling concept. We are actively involved in this process.

6. The American College of Surgeons' proposal addresses most of our concerns in an effective manner. We recommend the continuing development of this plan and look forward to participating in this process.

Mr. Chairman, we recognize and respect the opinions of our colleagues from whom you have heard or will hear. I am sure we are all united in our desire to effectively maintain access to quality care for our patients with responsible Federal cost control. Our organizations stand ready to work with your Committee as you address these issues.

Chairman STARK. Dr. Holtgrewe.

STATEMENT OF H. LOGAN HOLTGREWE, M.D., TREASURER, AMERICAN UROLOGICAL ASSOCIATION, INC.

Dr. HOLTGREWE. I am Logan Holtgrewe, a urologist from Annapolis, MD, and an officer of the American Urological Association. I wish to thank the committee for the opportunity to testify.

Urology has a small but vital group of services, the centerpiece of which is the treatment of prostate diseases. Transurethral prostatectomy [TURP] is the second most frequently performed operation under Medicare because it treats one of the most common diseases of the aging male.

Even modest charges in prostate surgery fees have a disproportionate effect on urologists. Unlike other physicians, they do not have a large number of other services with which to buffer reductions in any one.

New and important information is available through an independent national survey conducted in 1987 of all 7,744 American urologists. It found TURP constitutes 38 percent of their major surgery and that activities centered around this single operation represents one-third of their total patient workload.

Is TURP overvalued? Not according to this survey. American urologists rate TURP as the most complex and difficult to learn of all urological operations. The overwhelming majority felt that at least 75 to 150 must be performed during training in order to achieve proficiency—far more than any other urological operation.

American urologists, including the professors and teachers of urology, assigned TURP a relative value similar to that given it by Dr. William Hsiao in his paper appearing in the New England Journal of Medicine last fall.

However, the values assigned TURP by Dr. Hsiao and the Physicians Payment Review Commission in recent testimony before this committee have been dramatically reduced. We do not understand the methodology used in arriving at these changes.

What would be the effect upon urological care in our country if these new values for TURP were adopted?

American urologists would be stressed and caught between soaring malpractice premiums, rising overhead costs and now marked reductions in reimbursement for the operation which represents a large percent of their income.

Where is the incentive for the older urologist to remain in practice?

The loss of large numbers of older urologists would leave many with inadequate urological care. Rural America would be especially affected.

For example, in Texas, 40 percent of all urologists are over 55; 182 counties have no urologist and must rely on adjoining counties for their urological care. In 41 such adjoining counties, there is but one or two urologists, and in half these 41 counties, one or both urologists is over 55.

Retirement of significant numbers of these older urologists would have serious impact upon the availability of urological care in

Texas. Texas is not unique. Many other States reveal similar patterns.

Unrealistically low relative values assigned to surgical procedures cause another problem. They create a disincentive for the community urologist to accept difficult high-risk Medicare cases, thus requiring their referral to distant tertiary centers where queues will build and delays will occur.

Expenditure targets as recommended by the PhysPRC are opposed by our association. We feel it represents the rationing of health care.

How then can Medicare economies be achieved? Through the development and implementation of patient care guidelines to ensure that all medical and surgical services are appropriate, are required, and are most important, outcome effective.

Development of such guidelines will be a large task. Our association stands ready to provide panels of experts to aid the Government and its agencies in this undertaking.

As treasurer of our association, I am recommending to our executive committee that $500,000 be placed in this year's budget for this task.

Further, our association is currently in contact with the directors of all PRO's, nationwide, to assist them in their ongoing review programs of urology services.

Medical and surgical services have an intrinsic value. The work to date to determine these values is embryonic, crude, conflicting, and certainly controversial.

Our association feels the premature implementation of existing unproven value scales without further study and without preliminary regional trials would seriously impact urological care.

Further, we feel that budget-driven, across-the-board cuts in all surgical fees and additional deep cuts in specially targeted surgical procedures, including TURP, would be equally damaging to the delivery of urological care in our Nation. If immediate, short-term budget steps must be taken until guidelines are established, then small cuts in the reimbursement of all physicians would share the misery across a broad base and would be less disruptive.

Chairman STARK. Thank you, Dr. Holtgrewe.

[The statement of Dr. Holtgrewe follows:]

STATEMENT OF THE AMERICAN UROLOGICAL ASSOCIATION, INC.
H. LOGAN HOLTGREWE, M.D.

Mr. Chairman and Members of the Subcommittee:

My name is H. Logan Holtgrewe, M.D. and I'm a practicing urologist from Annapolis, MD. I'm also an officer of the American Urological Association. On behalf of the members of the AUA, I'm pleased to present their views on Federal budget for fiscal year 1990 proposals and the recommendations of the Physician Payment Review Commission (PPRC).

Federal Budget Issues

AUA feels strongly that more cuts in the Medicare program do not serve the interests of the program's beneficiaries. We believe that there is a limit to the number of times Congress can, or should, go to that well. Simply because the Medicare program is a large one does not mean that there is some extraordinary amount of "fat" that can be removed without affecting the access of Medicare patients to medical services. We strongly urge you to reject the Administration's request for a more than $5 billion reduction in Medicare spending. Every physcian knows what has happened to the Medicaid program which has been subject to intensive budget cutting. It would be a tragedy if we wind up with the same results in Medicare because an excess of budget cutting takes precedence over service to the program's beneficiaries.

AUA realizes that Congress will make some adjustments in Medicare spending and we urge you to seek the least disruptive path to do this. We feel that the least troublesome way to achieve Part B budget goals is to take a small amount of money from everyone. Small reductions, or a freeze, in payments to all physicians would probably meet spending targets without signifcant dislocations to any one group of physicians or the patients they treat.

Because of our concern about the impact budget decisions can have on beneficiary access to medical services, we urge you to reject deep cuts in either individual services or groups of services. We call upon Congress to reject the Administration's proposal for an eight percent across-the-board cut in all surgical, anesthesia and radiology services.

Likewise, we urge you to reject further cuts in so-called "over-valued procedures". AUA feels that the techniques for determining whether a procedure is over or under-valued are crude and not well understood. Therefore, we ask that the Administration's proposal to cut "over-valued procedures" by at least 12 percent be rejected.

If Medicare Part B reductions are needed, all physicians should contribute. Despite what some physicians may tell you, few doctors are in such financial straits that a small, across-the-board cut in Medicare payments would be catastrophic. We think the cuts proposed by the Administration would be far more troublesome. Congress must consider not only the short term budgetary impacts, but also the long term effects on the Medicare program. The cost of correcting in the future a mistake made today is considerably higher than being cautious now.

Is TURP "Over-valued"?

In 1987 Congress reduced payment for a number of surgical and diagnostic procedures, including transurethral resection of the prostate (TURP). AUA argued at the time that TURP was not over-valued. We felt that the only reason for including TURP was the fact that it is the second most common surgical procedure under Medicare. In the absence of an alternative to care for prostatic enlargement and its symptoms, TURP will continue to be a high volume Medicare procedure because the condition that it successfully treats is one that occurs commonly among older men.

TURP is now going to be subject to pre-admission review by PROs throughout the Medicare program. If the 1987 volume of 255,471 procedures is inappropriate, this intensive PRO review will reduce it. Pre-surgery PRO review is a preferable control than simply chopping off part of the payment.

Since 1987, more data on TURP has become available. An independent, nationwide study of urology practice completed in 1987 is the source of this new information about TURP and other aspects of urologic care. Based on that information, we reaffirm our belief that TURP is not "overvalued" by Medicare and we call on Congress not to single out TURP for payment cuts.

There are several reasons why AUA feels that TURP is not "over-valued" by Medicare. First, the 1987 survey of practicing urologists asked them to rate a series of urologic procedures according to their relative value. The survey sample was over 20 times larger than the one used by William Hsiao and the Harvard research team to develop its relative values for urology. The large sample of urolgists put TURP at a higher level of relative value than had Dr. Hsiao in either his 1985 or his 1988 analysis.

Since that time Dr. Hsiao has finished phase one of his work and PPRC has begun its extensive review of it. We have seen a variety of views on the relative value of TURP. Since 1986 it has been suggested that TURP is over-valued by 40%, 18%, and 36%; that its relative value is close to the Medicare charge level; and that it may be under-valued slightly.

The point of all of this is not to say that the AUA survey was right or that Dr. Hsiao was wrong, but to show you that determining relative value can be a very tricky business. This is amply demonstrated by the variation in the results of the different analysis. We urge Congress not to rely on this kind of analysis to make budget decisions.

Our concern over the limits of this analysis are shared by others. For example, we cite the Physician Payment Review Commission's draft report. In Chapter II-1, on page 2, PPRC notes "the data from those specialties already studied in phase 1 must be reanalyzed and in some cases individual specialties restudied with the improved methodology." The recognized need for these improvements argues strongly that Congress should not now use the simulation or analysis of PPRC, Dr. Hsiao or anyone else to make budget decisions at this time. There are ways to reduce spending without resorting to "over-valued procedures" and we urge you to explore them.

Another reason why TURP should not be considered an "over-valued procedure" is found in Dr. Hsiao's own work. When he published his initial results in October 1988, he wrote an article in the Journal of the American Medical Association of October 28 (Volume 260, No. 16) looking at the potential effects of a resource based relative value scale (RB-RVS). On pages 2431 and 2432 he included a table (table 2) which compared 1986 Medicare mean charges (mean submitted charges in 1986) with the RBRVs for the services of many medical specialties, including urology. He concluded that the relative value for TURP was 1,433 and the 1986 Medicare mean charge was $1,412. Dr Hsiao then noted the following: "Table 2 presents the RBRVs for four selected services in 18 specialties and compares them with 1986 mean charges submitted to Medicare. These data are presented to enable physicians and reimbursement experts to assess for themselves the reasonableness of the RBRVs and to see how they differ from the current charges."

Dr. Hsiao further notes in the same article "as Table 2 shows, the ratios of Medicare charges to RBRVs vary widely, from 0.16 to 1.62. In other words, current charges do not consistently reflect the resource cost of services." However the resource cost of a TURP was extremely close to the current charges. Can we then conclude that current charges for TURP "consistently reflect the resource cost of services"? If so, then how can it be argued that TURP is over-valued by Medicare? It is only by applying a "budget neutral" control to the analysis that Dr. Hsiao and PPRC concluded that TURP is overvalued (by very different amounts).

A final reason why AUA feels that TURP should not be considered overvalued by Congress is that the comparison of Medicare charges and relative values is generally a comparison of apples and oranges. By this I mean that the Medicare payment reflects the bundle of surgical services--all the things both before and after the operation, both in and out of the hospital, that the surgeon includes in the fee to the patient. From the

1987 study of urology, AUA has a good understanding of the surgical bundle for TURP. Thus we know that the Medicare payment reflects a number of individual services and visits. The measurement of TURP by Dr. Hsiao and PPRC does not reflect all of those inputs. In fact, PPRC is working on a model definition of the surgical bundle for all surgery to insure that meaningful comparisons can be made. That work is not complete. What this means is that these relative values measure only part of the surgical bundle, whereas the payment measures the whole bundle. Until such time as PPRC completes its work on the surgical bundle definition, including one for TURP, AUA thinks that these kinds of comparisons are inappropriate and inadequate, and should not be the basis for budget decisions.

Impact of Budget Cuts on Urologic Care

There is another consideration specific to urology which we think you need to look at very carefully. TURP is a major surgical procedure for urologists. It makes up a large part of their surgical case load and is an important revenue generator for the physician. Urology is a narrow specialty. That is, there are relatively few procedures and services that urologists provide to patients when compared to other medical specialties. If you cut payment for one procedure in another, broader specialty, those surgeons may be able to absorb that cut more easily and minimize some of the impact. The urologist, on the other hand, does not have the breadth of procedures and the dislocation can be magnified.

A recent study of Connecticut Medicare claims data for 1986 indicates that Medicare payment for TURP is 36% of the total Medicare revenue for urologists in that state. The 1987 study of urologists nationwide demonstrated similar levels of revenue from this procedure. That means that the degree of dependence on TURP is high and changes in payment are keenly felt. This reinforces the fact that a substantial reduction in payment for TURP would have a disproportionate impact on urology.

As noted earlier in our statement, the chief concern of Congress for the Medicare program must be to assure that program beneficiaries continue to have access to important health care services. Over the last decade, the number of urologists around the country has increased. This is fully documented in manpower studies conducted by AUA in 1975 and 1985. The impact of this growth is an increase in the ratio of urologists to population and a dispersion of urologists out of metropolitan areas and tertiary care centers into smaller communities and their hospitals. What this means for Medicare patients is that urologic services are more readily available close to home than they once were.

However, erosion of Medicare payment could have the effect of erasing these gains in the distribution of urologic care. Often payments are already lower in those non metropolitan areas and further cuts could be very disruptive.

For example, in the states of Alabama, Arkansas and Texas there was a substantial increase in the availability of urologic services in that period. Even so, in Alabama 41 of 67 countries have no resident urologist and another 15 countries are served by no more than two urologists. For example, Baldwin, Chambers, and Covington counties have only one urologist each. If these phsicians depart, patients will need to travel farther to receive urologic care. At best this is an inconvenience to patients and their families. At worst, it could be dangerous.

In Arkansas, nearly a third of the practicing urologists are over 55. Their early retirement would significantly impact the availability of urologic services. Of 75 countries, 54 have no urologists in them and each of 14 are served by two or less. Four of those counties are served only by urologists who are close to retirement age.

Texas perhaps shows a more dramatic picture. Nearly 40 percent of all urologists in the state are over 55. Of four urologists in Anderson Contry, only one is under 60. The youngest urologist in Angelina County is 54. Many other Texas counties are similarly situated or else have no urologists in them (203 of 254 counties). Patients in these counties can and do travel to get services. Some may not be too inconvenienced; others may be. The issue before you is to what extent will Congress act in ways that will increase the inconvenience, discomfort and risk of these elderly patients.

Once available only in relatively populus areas, urologists have moved to other communities and are meeting medical needs there. However, if the income stream is not available to sustain a practice, these physicians may be inclined to leave these smaller communities and rural areas in favor of better paying metropolitan areas. Some physicians may decide to retire since they feel that the efforts of medical practice are no longer worth the income to be derived from it. If they do, it may be very difficult to replace them with competent urologists because payment in the rural areas is low. Since payment in rural areas and small towns is already below that of the cities, to erode that further only makes it more difficult for these communities to sustain this medical care.

Now it might be argued that many of these services can be provided by other physicians, but such a result would not be consistent with good or economic medical care. A surgeon not trained in urology is likely to have little experience with TURP and would probably choose an open prostatectomy if called upon to deal with an enlarged prostate. That is an easier operation for a surgeon to perform, but it has a minimum hospital stay of eight to nine days and a much longer recovery period for the patient than does TURP. A TURP has a hospital stay of 3 to 4 days, a reduced mortality and morbidity rate, and a faster recovery time. The TURP is thus the more economical and efficient procedure not only for the patient, but also for the Federal government (the physician's fee for both procedures is about the same). Thus it is more efficient to have urologic services available to these patients than to not have them available. Certainly from the point of view of the patient, it is better that they be closer to home and family during the surgery and follow-up care.

It is extremely important that as Congress evaluates budget options that it look closely at the impact these policies may have on the delivery of health services in small communities and rural areas. Already the rural hospitals are concerned about the impact of DRGs. We urge you to be similarly cognizant of rural physicians of all specialties. Remember that Medicare beneficiaries need not only primary care, but also other kinds of specialized medical care. This is dictated in large part because of the chronic illnesses that frequently afflict older people and require specialized attention and intervention.

Recommendations Of The Physician Payment Review Commission

I'd like to turn now to the recently announced recommendations of the Physician Payment Review Commission (PPRC). PPRC has spent much time working on this report and AUA has been an active participant in several aspects of it. We applaud the openness of their process and the excellence of their staff. While AUA does not always agree with their conclusions, we recognize that PPRC has tried hard to resolve some difficult issues and has been open to opposing views.

AUA is, however, very concerned that there may be a rush to judgment in favor of PPRC's new fee schedule without adequate opportunity for completing the kinds of work that PPRC recommends and without adequate testing of the concepts in the real world. The PPRC report is filled with recommendations for additional studies and work. AUA urges Congress to allow those efforts to go forward before deciding on the utility of this particular method of determining Medicare payments to physicians. For example, it appears that eight of the eighteen medical specialties reviewed for the Hsiao study are being reanalyzed in one fashion or another. That fact should argue strongly for delay in adopting the new fee schedule.

Medicare now operates with a fee schedule for each physician, based on the charge history each physician has established. PPRC proposes moving from a highly individualistic set of fee schedules to a national Medicare fee schedule. The primary basis would be resource costs as opposed to charges.

Congress must decide that moving to this national fee schedule is appropriate and would lead to program improvements. However, a new fee schedule is just as likely to introduce problems into the payment system as did the current process. We can all acknowledge that the way Medicare payment is now determined is not perfect; however, we would be naive if we assumed that a new system, whatever its basis, would not introduce its own distortions. With that in mind we must urge great caution in the Congressional consideration of these proposals to dramatically alter the current system.

AUA questions whether or not resource costs should be the primary basis for determining Medicare payment. Even conceding that there are some inappropriate disparities in the payment for different kinds of services, the science of analyzing resource costs is so new that we have little confidence that such a system will improve the current situation to any great degree.

PPRC has accepted as the basis for the RVS the initial estimates of physician time and effort developed by Dr. Hsiao at Harvard. PPRC acknowledges that much work still needs to be done to refine that methodology. That is why we believe Congress should defer action on of a fee schedule based on resource costs until the further analytical work has been completed. Significant questions remain about the pre and post work measurements, the quality of the vignettes, the way in which physicians responded to the questionnaires, and other technical aspects of the study. The results are very important to Medicare patients, physicians and the government. It is essential that the work be completed properly before the conversion to a new system is made.

We agree with the Commission that any fee schedule should incorporate practice costs calculated separately. AUA would be concerned if the use of an index averages costs in such a way that many physicians will not recoup their real costs of practice because they don't meet some "average" definition. We think the practice costs might have to be figureed more on an individual basis in order that physicians be treated fairly in all parts of the country. The cost of living, as well as the cost of practice, may need to be examined in order to assure payment equity among physicians. Some payments in certain geographic areas are badly in need of upward adjustment; however, cost of living differences are real and important and cannot be ignored. To suggest that surgeons in large cities should have their Medicare income reduced by 25% is frightening. Such a conclusion totally disregards the realities of living many people face in those areas. Other professions may adjust their fees to reflect cost-of-living. Why should physicians be singled out for this unfair treatment?

We are disappointed that the Commission does not want to include a factor for additional specialty training because we think that specialized training is an important component of the service that the patient receives. We do not believe that simply because two different kinds of physicians, one specialized and one not, use the same service code means the patient has received the same service. We believe that there are efficiencies, economies and intensities that a specialized physician brings to a service that should be accommodated in any payment structure.

The AUA is working with PPRC on the definitions for evaluation and management services, as well as on the global surgery package. We believe that PPRC has done some excellent work in this area. Because work on these definitions is not finished, it is very difficult to make comparisons between evaluation and management services and surgery. Therefore, we think those comparisons should await a standardized set of definitions, which is the object of this effort. Until everyone is speaking the same language, comparisons will be relatively meaningless.

PPRC has recommended that there be a limit on balance billing on all unassigned claims. The American Urological Association objects to that proposal, preferring that the balance billing limits be associated with the income levels of beneficiaries. AUA believe that mandatory assignment should apply to low income Medicare beneficiaries. On the other hand, we see no reason why physicians, non-Medicare patients and taxpayers should have to subsidize the cost of medical care for those Medicare beneficiaries who are perfectly capable of paying the charges in full.

PPRC cites the need to monitor the impact of the new fee schedule if its recommendations are adopted by Congress. This suggests a degree of uncertainty about the proposals which we find very troublesome. AUA believes it would be better for Congress to take the recommendations and use demonstration projects or regional testing to see if they work as intended. We think pre-testing, rather than after-the-fact testing, would be the way to go with this new program. We believe that many of the impacts of such a system can not fully be appreciated in advance, regardless of the skill of the simulators; therefore, we urge demonstration projects before adoption of this or any other new national fee schedule. This does not mean that appropriate monitoring is not useful. However, we think the monitoring should be of a system that has been tested and upon which there is greater agreement.

The most controversial part of the PPRC recommendations is the national expenditure target for physician services. While we recognize the difficulty of dealing with the current budget situation, we do not believe that an arbitrary expenditure cap or budget ceiling is the way to go. AUA thinks it will lead to rationing of care. In those nations where budget targets have been put in place some patients have experienced long waiting lines or denial of care. We do not believe that is an acceptable trade-off for the American public. We believe that Congress should reject the recommendation for a national expenditure target for physician services. It is entirely too simplistic an approach to an extremely complex problem.

Recognizing that program growth is a serious concern and also believing that physicians have a responsibility to help deal with those problems, we urge Congress to work with the physician community to develop standards of medical care. There is no question that medical uncertainty causes some inappropriate utilization. To the degree the physician community can reach a consensus, that can reduce inappropriate utilization. We think that medically derived standards of care are a far better approach to dealing with program growth.

As part of the development of these guidelines, we urge Congress to create an environment in which physician organizations feel free to develop and publicize these standards. Many physician organizations are now concerned that, if they are aggressive about doing this, they will run afoul of the Federal Trade Commission or the Anti-trust Division of the Justice Department. We believe that Congress should create a climate in which the physician community can work with other public interests to develop effective standards of care that will curb inappropriate utilization. The absence of this climate will slow the development of these guidelines and certainly reduce the appropriate medical input.

Medical care is sufficiently complex these days to require that the specialists who perform services be the ones most involved in the development of standards of care. It simply cannot be done by those who are unfamiliar with the particular services in question. Do not assume that all physicians know all things about all medical practice. This means that AUA and urologists should develop the standards for urologic care. Other specialists should examine their own fields. These standards should then be carefully reviewed by other interests before adoption as part of the overall payment mechanism.

Part of this activity should be a strengthened research effort examining the effective use of various medical practices. This program should look at areas where medical uncertainty exists and try to help physicians resolve that uncertainty. We are encouraged that Congress is moving in this area.

Finally, we concur that PPRC is on the right track when it recommends some limits to the kinds of incentive plans that should be used in health maintenance organizations and other prepaid settings. While we do not object to all incentive programs designed to encourage appropriate use, we believe that those which put the referring physician at great financial risk can lead to inappropriately low utilization of services. We believe that Congress should heed the recommendation of PPRC in this regard.

In conclusion Mr. Chairman, let me congratulate the Physician Payment Review Commission and its staff for the extensiveness of it analysis and the willingness of the Commission to try to accommodate many important needs and concerns. We believe, as PPRC apparently does, that a great deal more work needs to be done on the design of a new fee schedule for Medicare. We hope that you will also recognize that need and allow more work to go forward before you act to put a program in place.

We disagree with PPRC that resource costs should be the primary means of determining payments. We think that other factors need to be incorporated and that through a balancing of these inputs a variety of diverse goals can be achieved. We believe strongly that the patients who are served by the Medicare program should continue to have access to the full array of medical services that are available to anyone else in the United States. Congress should not take steps now that may make the Medicare patient a second class citizen when it comes to medical care. That would be a tremendous disservice to the patients who rely upon this program.

Mr. Chairman, this completes my statement and I would be pleased to answer any questions that the Subcommittee may have.

Chairman **Stark**. All of you seem to have some problem with the relative value scale. It is very nice to find all four of you with me challenging the AMA.

By the way, that is where you might get a few thousand dollars for the $500,000 you are trying to raise.

Dr. **Holtgrewe**. I will point out that the American Urological Association had nothing to do with that.

Chairman **Stark**. But there have been some chinks in the armor of disagreement. The AMA seems to think they strongly support a fee schedule. The American College of Surgeons has tossed the first hat in the ring and said, "How about half and half, half of present fees and half relative value," which I think is the best offer we have had today. At least it is an offer.

What I would like to suggest to all of you is that this is not a decision that I think this committee is prepared to make. I hate to go back to PhysPRC, but I would be happy to take any other interest group. You all are going to have to decide on a relative value scale that is generally acceptable to the medical profession in its broadest scope. There is no way we are going to be able to sort it out.

I cannot spell 9 out of 10 of the procedures, and I don't know what the 99 out of 100 are. You do not want me and my equally well-informed colleagues trying to decide who ought to get more for what. I can understand various groups feeling a concern, but it ought not to be Congress.

I would urge all of you to go back to the drawing boards and negotiate among specialties and eventually among whomever is going to work out what the relative value scales are going to be. But if in fact there is going to be one, it seems to me we have to have you all in the ballpark.

As for overpriced procedures, let me again defend the subcommittee, if necessary, and indeed the administration, which is not necessarily my role in life. The overpriced procedures were not based on the shallow end of the value scale.

In its simplest form, as it was presented to us, there were two commercial insurers in a major group plan, Ontario and Medicare, in a sense five payers of procedures. The overpriced procedures, although many of them were identified in volume, were not looking after some exotic thing like Lyme's disease, but the overpriced procedures were based on what other people in the market were paying for the procedures that were identified.

It was suggested to us by an independent commission that these were procedures that would bear reduction in fee payments based on what presumably the same doctors were charging other folks. We found that, and the committee repeatedly inquired of the administration during markup to justify the fact, they were not picking numbers out of the air. They were comparing what was paid in different parts of the country by Blue Cross/Blue Shield and other large groups.

So your quarrel is with people making those decisions and not with the committee. At some time we will have to have a person to translate these highly technical differences to us.

It is being suggested again this year in the administration's budget proposal, and I don't know if it is the final recommendation, that we do that once again.

So I would urge you, if you have a quarrel, we will be constrained to save money. The Budget Committee has already acted in that manner.

In the absence of a complete revision of how physicians are being reimbursed, it looks likely it will be some across-the-board cuts and some cuts in overpriced procedures. But that is nothing we generate here. That is going to have to come from outside recommendations.

As to rationing, I have heard that from time to time. It doesn't trouble me because we already have it. The number of people who come into the county hospital in my district in a diabetic coma or shock because they did not get diagnosed earlier and treated by drugs, or the number of pneumonia cases that might have been bronchitis treated earlier, that is to me a way of rationing.

Now, my county has institutionalized it by hiring a former priest who sits in judgment on it. That is not acceptable to me, but it is out there.

I would like to ask particularly Dr. Lindesmith and Dr. McCollough if they have any opposition to our bill, to my bill, to restrict referrals where the physician has an ownership in orthopedics, in physical therapy, and that type of lab and for thoracic surgeons, CAT scanners, and MRI's and whatever things you might use.

Have either of your groups taken a position?

Dr. LINDESMITH. No, sir, we have not. It seems to me logical and rational.

Chairman STARK. That is something I would like to hear more about.

Dr. McCollough.

Dr. MCCOLLOUGH. Our academy has referred that for consideration by our ethics committee and our committee on health care financing. Our preliminary position is favorable.

Chairman STARK. You will be hearing from the AMA again.

Dr. HOLTGREWE. Congressman, urology is again different. Several years ago the stone busting technique came along. It is a $3 million piece of equipment. In many instances the community cannot afford it.

The urologists in the community banded together, put up their own money, and brought it to the community.

Chairman STARK. Would Dr. McCollough or Dr. Lindesmith be apt to refer anybody to your lithotripter?

Dr. HOLTGREWE. The ones I know in my area, the owners let anyone come in who is a urologist.

Chairman STARK. What I am suggesting is that in our bill, and we have had some criticism, if it is a match-in that takes you, a urologist, to supervise the operation and you really own it—I don't mean you put in $500 in a big note that you know you don't have to pay, but you put up the money, hire the employees, you run it—then I think that is off the books. I think that is OK.

Dr. HOLTGREWE. That is basically the arrangement.

Chairman STARK. If you are the only one who refers it, now if you sold interests in that operation to every primary care physician in town to, in a sense, to generate some referrals to you, that is where we are trying to draw the line.

Dr. **Holtgrewe**. These were simply purchased by urologists because they were the ones who had the technology and they could not have it any other ways.

Chairman **Stark**. If three internists have one and share a common waiting room, I see no problem. It is where referrals seem the only possible logical reason.

Dr. **Holtgrewe**. Our association would be opposed to that, as well.

Chairman **Stark**. The difficult part of this whole bill is to sort out where, in fact, the ownership really is.

Dr. **Holtgrewe**. Where it is legitimate.

Chairman **Stark**. Yes. I don't know what legitimate is in that instance.

Dr. **Reinecke**. Our legal analysis of your bill suggests that ophthalmologists would not be able to dispense in certain parts of the country. There may be other instances like that where some preferred vendors are, as long as they tell the patients what is going on.

Chairman **Stark**. I met with 15 ophthalmologists in my district over the weekend. They are convinced that the ophthalmologist's treatment after surgery has been ginned up to where the optometrists are hand-in-glove on the deal.

Dr. **Reinecke**. As I commented in my testimony, I think your bill is good on that score.

Chairman **Stark**. I hope you will help us in sorting out what is more of a referral operation than a jurisdictional dispute as to people qualified to provide treatment. It is a thorny road and I hope your own disciplining of your members could help us in that.

Mr. Levin.

Mr. **Levin**. The four of you represent the four surgical specialties that would be hit the hardest. Maybe it is not fair that you are brought together that way. Let me take advantage of it. Maybe it is a good setting to ask each of you just to pick out what you think is the most serious flaw in the RVS study and result.

If each of you had to pick out what you think is the softest spot in about a minute, what would you say?

Dr. **Lindesmith**. In our opinion, the most serious flaw in the methodology is conceptual. That is that the whole study was based on the premise that there was a marketplace that did not work—our evidence shows the marketplace indeed has worked—and there was a disparate distribution of funds between surgeons and nonsurgeons.

Their premise over 10 years has been to correct that perception and at the same time try to reduce the budgetary requirements of our Medicare population. Looking at that at the outset, you could predict it would not work. Their flawed conceptual idea is that the fees for surgeons are too high and the fees for nonsurgeons are too low because the marketplace has not worked.

Dr. **Holtgrewe**. In urology, we conducted through an independent research firm a survey of all urologists in the United States in 1987. We asked them to assign a relative value to the common procedures which we performed.

The results were comparable to the results Dr. Hsiao reported in the New England Journal of Medicine in October. Since then there have been changes. I don't know how it changed.

I don't understand the methodology. Complexity is a factor in what is done. Some of our procedures are extremely complex. They don't seem to appear. Complexity seems to be dropped into a black hole and now there is a work factor that appears.

We don't understand the new numbers. We thought we understood the old ones.

I would answer that question by saying that in a national survey of all urologists, the numbers do not match up with what Dr. Hsiao presents. I don't know who he asked. We don't agree with the numbers presented in his books and the figures represented by the PhysPRC.

Dr. REINECKE. I concur with the idea of that philosophy. I think it did introduce a lot of bias. You asked for specifics about that. Probably because the four of us were the first studied led me to believe that they did not have the technical expertise to do a good job.

In their enthusiasm for getting it through, I think they have taken shortcuts that would be probably unwarranted. So we have a great deal of problem with it. We recognize that it should be redone.

I must admit we are somewhat annoyed that we have to pay for it to be redone ourselves since we did not initiate any of their monkeybusiness. So we are really caught on the horns of a dilemma here.

The bills for redoing this are very substantial. It was a huge study that was taken on. No one can deny the vastness of the implications of this study. To do it and not plan a second phase to correct the things done the first time around, I think, in retrospect, was probably inappropriate and probably the budget was way too small for this kind of a problem.

I want to try to stay away from implying that Dr. Hsiao, himself, did not do his best. I am sure the researchers did their best, but they were extremely shortchanged when it came to medical input.

They had nonmedical people doing the filling in of the statistics. When we made recommendations, they were not taken to heart and appropriate changes made. We were very disappointed in that.

I can understand their reluctance to change their study, but nevertheless, I think you are getting the gist of our problem with the study.

Dr. McCOLLOUGH. Congressman, the academy's major problem with the study relates to the fact that great emphasis is based upon time. We feel that the total amount of time associated with procedures in orthopedics was not accurately represented in the study.

The estimates of time were at great variation with our own studies of procedure time which we shared with the Commission and which we would be happy to share with you. These variations were up to 80 percent.

We were advised also by our researchers that total work represents 82 percent of the RB RVS formula, so it is not an insignificant factor in orthopedics.

We also had a problem with cross-specialty links and the procedure of carpal tunnel which is not linked with the broad specialty of orthopedics.

Mr. LEVIN. The chairman pointed out there is a parallelism with the results of the Hsiao study as modified, and other analyses of overpriced procedures.

Are those just coincidental? Do you think he took those into account so that in a sense it is magnifying what you think is a mistake? How do you account for this not complete but substantial parallelism?

The chairman referred to various insurance company studies, et cetera. The very areas or some of the areas that the Hsiao study and subsequent work by the Commission indicate are overvalued are considered through other studies overpriced.

In practical terms, we look at these various studies. We don't pretend to be total experts. The staff helps with that. We try to be as knowledgeable as possible. But they seem to move these various extremes in the same direction. That is what you are fighting.

Is it just coincidence? I don't think you call it conspiracy, obviously. What is it?

Dr. REINECKE. I cannot speak for the other specialty. Several events occurred in ophthalmology, the most being cataract surgery. One was intracapsular cataract extraction without an implant.

Then the technology changed. When we started putting in implants, the price went up. But those were the two prices discussed. That is the reason given for cataract surgery being so overpriced.

Most people argued that once it was in place for a while, the complexity factor should have gotten less. After a 30- or 40-percent reduction, we think it is time to stop. We think there are reasons in the past that these inappropriate things were not considered overpriced.

There are a lot of things in the present fee structure that need addressing. Some older physicians get less for the same procedure than someone right out of school. We are willing to look at these things and readdress them, but we feel very uncomfortable in getting on a fast track with these things where we are taking on a whole new system.

So I sympathize with the direction you are taking. It is no accident that they picked the most numerous procedures to call overpriced. Those are going to be the biggest budget savings.

Mr. LEVIN. I think your association opposed the reductions from the very beginning.

Dr. REINECKE. We suggested ways to in fact cut savings, make savings to the Government, and the Congress did take those savings to the last reconciliation package.

Mr. LEVIN. Dr. McCollough, here is what I think. On the first page, you say:

> The proposed RB RVS would shift billions of dollars from surgical care, where curative and restorative outcomes are clear, in order to increase the compensation for millions of encounters and services where volume constraints are not established by current methods and where the skills employed and patient benefits to be obtained are much more difficult to document.

There is a subtle choice of language there. I am not sure whether the word, for example, "encounters," is that a term of art?

Dr. McCollough. No, sir, it is not an art term.

Mr. Levin. It is rhetorical?

Dr. McCollough. It is a term for office visit.

Mr. Levin. Why do you call them encounters?

Dr. McCollough. Patient encounters.

Mr. Levin. Is that the way physicians talk about them, as encounters? They do? I think a lot of us start with the notion that there has been an undervaluation of, in our society, of something that may be harder to define that would involve a lot of preventive care, hopefully.

The word "encounters," it seems to me, kind of dismisses them. You do not intend to do that. You are not saying here that surgical care is clear in its curative outcome and, therefore, we have appropriately valued it while the rest of it is kind of vague and ephemeral and maybe not of much use?

Dr. McCollough. No, sir, not at all. We would agree that primary care services have been undervalued. This is meant to address a volume issue. We recognize the control of surgical procedures, and the evaluation of outcome of surgical procedures is perhaps easier to measure than those of nonsurgical services.

Since a shift of money is occurring to less well-measurable services, we believe that needs to be more closely evaluated.

Mr. Levin. OK, Mrs. Johnson.

Mrs. Johnson. Mr. Chairman, in view of the fact that I have to leave at 4:30 and I know some other members are under time constraints, I am going to thank the panel.

Mr. Levin. All right. I guess we are finished with this section. Thank you very much. It has been most illuminating.

All right. We are down to our last panel. We will keep in mind Mrs. Johnson's time requirements.

Dr. Rogers, Dr. Arens, Dr. Bishop, and Dr. Sharfstein. Let's see. I guess we will proceed in this order so that we know. Let's proceed with Dr. Rogers, and then let's go down the line.

Again, your testimony will be in the record. It is late. We are always sorry when the last panel is started late, but maybe you can take advantage of the testimony that has come before you and highlight your testimony and address any of these other issues, if you would. Thank you very much.

STATEMENT OF LEE F. ROGERS, M.D., CHAIRMAN, BOARD OF CHANCELLORS, AMERICAN COLLEGE OF RADIOLOGY, ACCOMPANIED BY JAMES M. MOOREFIELD, M.D., VICE CHAIRMAN

Dr. Rogers. Thank you, Mr. Chairman. I have abbreviated the testimony in view of the time.

My name is Lee Rogers. I am a practicing radiologist at Northwestern University Medical School in Chicago and chairman of the board of chancellors of the American College of Radiology. I have with me today Dr. James Moorefield, a radiologist from Sacramento, CA, who is vice chairman of our board and chairman of the committee which worked with the Health Care Financing Administration to develop the radiology fee schedule.

I would like to thank you for asking us to address issues raised in the President's budget recommendations and in the report of the

Physician Payment Review Commission and for allowing us the opportunity to update the progress of implementation of the radiology fee schedule.

President Bush's budget proposals includes a recommendation that payment levels for radiology be reduced by 8 percent. We do not believe such wholesale, across-the-board reductions are productive of real reform in Medicare reimbursement. We have worked closely and successfully with HCFA over the last year and a half to develop a rational system. Let's give that major change a chance to work before invoking such arbitrary recommendations.

However, the President's proposal to limit Medicare reimbursement to the level paid the specialist trained to perform the procedure or service should receive serious consideration.

The Physician Payment Review Commission has spent considerable time in the last 2 years reviewing the resource-based relative value scale. We will provide the subcommittee with copies of our statements to the PhysPRC, but let me summarize our position on the resource-based concept.

We contend the development of an RVS and fee schedule for Medicare is best based on historical charges, modified by physician judgment. We call this method "experience-based." This provides a better base than an imperfect estimate of resources used.

The charges in the RBRVS, in its present state, are heavily weighted simply by the time spent by the physician as others have testified. The advantage of an RVS based on charges, and modified by the professional judgement of physicians, is that charges reflect underlying demand and professional skill and expertise, as well as practice costs and the time involved.

The PhysPRC has also made a series of recommendations regarding expenditure targets and utilization reviews to determine the effectiveness of medical care. The ACR believes there are many appropriate steps which can be undertaken to assure appropriate and effective care.

First is to assure that procedures are performed by the physicians best trained to perform them.

Second, there should be utilization screens for those practitioners who self-refer patients for testing or other procedures.

Third, steps should be taken to assure that reasonable standards of care are established. As an example, the ACR has established guidelines and standards for performing many radiologic procedures such as mammography, and we have worked with the obstetricians and gynecologists to develop guidelines for the use of ultrasonography in pregnancy. And this effort is ongoing to assure continued upgrading in keeping with our rapidly evolving specialty.

We are concerned about mechanisms to control expenditures or utilization if the development includes relying on data that exists or is to be collected through the current Medicare carrier mechanism.

It is our experience that data collected by the carriers are incomplete and frequently erroneous. In fact, the first attempt to develop conversion factors for the radiology fee schedule fell short because of numerous problems existing in the Medicare carrier data base.

We would favor, and have more confidence in, utilization screens developed by physicians using their experience and professional judgment, rather than those that rely on data collection systems in which we have little confidence.

The PPRC has recognized the need to closely examine the experience of the ACR and others in developing specialty-based relative value scales and fee schedules.

The ACR would like to compliment HCFA for their cooperation through the process of developing the radiology relative value scale. But while HCFA has been cooperative, we have become aware of problems in the regional administration of the Medicare system which will hamper the implementation of any national reimbursement fee schedule.

The first is carrier operations. They appear to be autonomous. The Medicare carriers across the country conduct their business inconsistently. There is considerable variation in the interpretation and application of federally mandated rules and regulations. The proficiency and accuracy of data collection varies.

The willingness of carriers to work with physicians also varies, to say nothing of their willingness to work with patients, the beneficiaries. Some are extremely cooperative, and others are quite the opposite.

Based on our experience, we suggest the possibility that serious reevaluation and revamping of the carrier payment mechanism might result in a reduction in Medicare expenditures without reducing payments to either hospitals or physicians or benefits to the elderly.

A manifestation of these carrier problems is our recent experience with their promulgation of inaccurate conversion factors for the radiology fee schedule.

The second problem is the wide geographic variation in radiology and presumably all other physician reimbursement. Some of these variations are based on traditional rural/urban delineations, but some seem to occur rather randomly. This is compounded by the variation across states.

We have found that the range in conversion factors for the radiology fee schedule is 2½ times from the highest to the lowest unrelated to cost of living, cost of practice, Consumer Price Index [CPI], or any other known economic measurement standard. This is an issue which we feel should be addressed as quickly as possible.

Despite the problems encountered in implementing the radiology fee schedule, it is important to note that it did not take years to accomplish. As we told this subcommittee 2 years ago, medical specialty groups have the experience and necessary resources to develop rational relative value scales upon which Medicare payments may be made.

It was not and is not necessary to await theoretical studies in order to accomplish this goal. We believe the same is true for setting standards for utilization of medical procedures, and we stand ready to work with the Congress to accomplish that goal, as well.

Thank you.

[The statement of Lee F. Rogers, M.D., follows:]

Testimony of the American College of Radiology

before

Subcommittee on Health

Ways and Means Committee

April 17, 1989

Thank you Mr. Chairman. My name is Lee Rogers. I am a practicing radiologist at Northwestern University Medical School in Chicago, Ill. and serve as Chairman of the Board of Chancellors of the American College of Radiology. I have with me today Dr. James Moorefield, a radiologist from Sacramento, California, who is Vice-Chairman of our board and chairman of the committee which worked with the Health Care Financing Administration to develop the radiology fee schedule.

I would like to thank you for asking us to address issues raised in the President's budget recommendations and in the report of the Physician Payment Review Commission and for allowing us the opportunity to update the progress of implementation of the radiology fee schedule. We would also like to ask the subcommittee's permission to submit additional information relative to the radiology fee schedule for the record at a later date.

President Bush's budget includes a recommendation that payment levels for radiology be reduced by eight percent. We do not believe such wholesale, across the board reductions are productive of real reform in Medicare reimbursement. It was such a recommendation that caused the ACR to come to Congress with a proposal for a more rational system of radiology reimbursement. The Congress agreed and we have worked closely and successfully with HCFA over the last year and a half to develop a rational system. Let's give that major change a chance to work before considering such arbitrary recommendations.

One recommendation which we feel should receive serious consideration is the President's proposal to limit Medicare reimbursement to the level paid the specialist trained to perform the procedure or service. In our study of Medicare payments, we have been surprised to find non radiologist physicians are reimbursed at higher levels than radiologists for the same radiologic procedure in a great percentage of cases. We are aware of similar anomalous patterns of reimbursement in other specialty areas. We can see no legitimate reason for this practice to continue and it is likely that such a proposal would result in significant savings.

The Physician Payment Review Commission has spent considerable time in the last two years reviewing the resource-based relative value scale. We have presented testimony to the PPRC on the Harvard RBRVS study as well as the radiology relative value scale.
We will provide the subcommittee with copies of our statements to the PPRC, but let me summarize our position on the resource-based concept.

We contend the development of an RVS and fee schedule for Medicare is best based on historical charges, modified by physician judgement. We call this method "experience-based." This provides a better base than an imperfect estimate of resources used. The charges in the RBRVS, in its present state, are heavily weighted by the time spent by the physician. The advantage of an RVS based on charges, and modified by the professional judgement of physicians, is that charges are based on the existing market for medical care and therefore reflect underlying demand and professional skill and expertise as well as practice costs and the time involved.

The PPRC has also made a series of recommendations regarding expenditure targets and utilization reviews to determine the effectiveness of medical care. The ACR believes there are many appropriate steps which can be undertaken to assure appropriate and effective care. First is to assure that procedures are performed by the physicians best trained to perform them. Secondly, there should be utilization screens for those practitioners who self-refer patients for further medical care. Thirdly, steps should be taken to assure that reasonable standards of care are established. As an example, the ACR has established guidelines and standards for performing many radiologic examinations and this effort is ongoing to assure continued upgrading in keeping with our rapidly evolving specialty.

We are concerned about mechanisms to control expenditures or utilization if the development includes relying on data that exists or is to be collected through the current Medicare carrier mechanism. It is our experience that data collected by the carriers is incomplete and frequently erroneous. In fact, the first attempt to develop conversion factors for the radiology fee schedule fell short because of numerous problems existing in the Medicare carrier data base.

We have recently been required by law to begin another data collection activity which is proposed to form the basis for utilization review. The use of ICD-9 codes for disease classification began on April 1. We have serious concern about screens developed using this data. We would favor, and have more confidence in, screens developed by physicians using their experience and professional judgement, rather than those that rely on data collection systems in which we have little confidence.

The PPRC has recognized the need to closely examine the experience of the ACR and others in developing specialty based relative value scales and fee schedules. Much can be learned from our experience. These experiences can be helpful to this subcommitee and the Congress as you develop fee schedules for othe medical specialties.

First, the ACR would like to compliment HCFA for their cooperation through the process of developing the radiology relative value scale. But while HCFA has been cooperative, we have become aware of problems in the regional administration of the Medicare system which will hamper the implementation of any national reimbursment fee schedule.

The first is carrier operations. They appear to be autonomous. The Medicare carriers across the country conduct their business inconsistently. There is considerable variation in the interpretation and application of federally mandated rules and regulations. The proficiency and accuracy of data collection varies. The willingness of carriers to work with physicians also varies. Some are extremely cooperative and others want "freedom of information" requests for every question.

Based on our experience, we suggest the possibility that serious re-evaluation and revamping of the carrier payment mechanism might result in a reduction in Medicare expenditures without reducing payments to either hospitals or physicians or benefits to the elderly. HCFA should be given greater authority to review carrier operations and audit trails should be established to assure carrier accountability for disbursement of funds. We believe that such action would result in significant savings to Medicare.

A manifestation of these carrier problems is our recent experience with their promulgation of inaccurate conversion factors. It is difficult, within the limits of available data, to assure that the cut in radiology payments in 1989 is no more or less than the three percent mandated in the law. We are working with radiology practices across the country in an attempt to ensure that accurate calculation of conversion factors has taken place.

The second problem is the wide geographic variation in physician reimbursement. Some of these variations are based on traditional rural/urban delineations, but some seem to occur randomly. This is compounded by the variation across states. We have found that the range in conversion factors for the radiology fee schedule is two and a half times from the highest to the lowest unrelated to cost of living, cost of practice consumer price index (CPI) or any other known economic measurement standard. This is an issue which we feel should be addressed as quickly as possible.

Considering the problems encountered in implementation of the radiology fee schedule, it is important to note that it did not take years to accomplish. As we told this subcommitee two years ago, medical specialty groups have the experience and necessary resources to develop rational relative value scales upon which Medicare payments may be made. It was not and is not necessary to await theoretical studies in order to accomplish this goal. We believe the same is true for setting standards for utilization of medical procedures and we stand ready to work with the Congress to accomplish that goal as well.

Mr. LEVIN. Thank you very much.

Dr. Bishop.

STATEMENT OF MICHAEL D. BISHOP, M.D., CHAIRMAN, PHYSICIAN PAYMENT COMMITTEE, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Dr. BISHOP. Thank you. Mr. Chairman, and members of the subcommittee, I am Mike Bishop, an emergency physician in Bloomington, IN. I appear today on behalf of the more than 12,000 members of the American College of Emergency Physicians.

Emergency medicine was not included in the first phase of the Harvard Resource-Based Relative Value Scale Study. However, emergency medicine is be examined in the second phase. The Harvard project represents a major contribution to the development of an RVS for physicians' services that more accurately reflects the actual inputs needed to produce these services. The PhysPRC has proposed some important modifications to the Harvard methodology that we feel may make it feasible to use a resource-based relative value approach.

In recent years, legislative changes have been enacted to redress some of the current payment imbalances for primary care services, including emergency department visit services. The issue of special recognition for primary care services arises because more time will be needed before a new payment system based on resource costs can be implemented.

We hope this subcommittee will continue to recommend differential treatment for primary care services, including emergency department visits, in connection with any payment actions taken by Congress on an interim basis.

We have some concerns about the PhysPRC's recommendation to move rapidly and implement a Medicare fee schedule in 1990. There is still much more to be learned before major revisions in payment rules are adopted.

The impact on both beneficiaries and physicians of some of the proposed changes is not very clear at this time, but could be significant. Our own participation in the Harvard study, for example, is only just beginning. More time may be needed to develop the data needed before a workable fee schedule can be adopted.

We urge that Congress keep these considerations in mind when deciding the appropriate time to initiate further physician payment reforms.

ACEP agrees with the PhysPRC that there are serious problems with use of the current codes in defining physician work, particularly some of the codes for emergency department visits. The commission is recommending that the coding system be revised so that time would be used as a significant factor in establishing different levels of service.

There is a unique difficulty with linking the valuation of emergency services to time. Many emergency services need to be provided quickly. In fact, their value lies in their quick application. ACEP believes that the value of emergency services should be more closely linked to such factors as knowledge, skill, effort, and stress, and not disproportionately to time.

One of the major recommendations from the PhysPRC calls for a national target expenditure plan. ACEP opposes this recommendation in its current form, primarily because it fails to recognize the nature of the demand for emergency services by the Medicare population.

Emergency physicians do not determine, nor control, the number of patients who present to emergency departments. Moreover, ACEP strongly opposes any steps that would discourage patients from seeking medical care when they are acutely ill or believe they need urgent medical attention. However, if Congress decides to adopt an expenditure target plan, emergency services should be specifically excluded from that plan.

Finally, I would like to share our views about the need for improvements in Medicare's assignment procedures. Based on our detailed study of Medicare data on emergency department visit codes, emergency physicians appear to have the highest assignment rates of all physicians, accepting assignment on approximately 90 percent of all claims.

We understand that the commission has, in principle, endorsed the need for making changes in Medicare's assignment policy where beneficiaries have no meaningful choice of provider.

Since patients who present with emergencies have no meaningful choice of provider, and since the emergency physicians who treat them have no choice in the selection of which patients they treat, we agree that Medicare's current assignment rules should be changed under a new Medicare fee schedule.

If, as part of this reform process, payments for emergency physician services are reasonably valued and paid appropriately, the American College of Emergency Physicians is prepared to support the acceptance of such payment levels as payment in full, thereby relieving Medicare patients of balance billing obligations.

Thank you very much.

[The statement of Michael D. Bishop, M.D., follows:]

STATEMENT OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Mr. Chairman and Members of the Subcommittee, I am Michael Bishop, M.D., F.A.C.E.P., a practicing emergency physician in Bloomington, Indiana, and Chairman of the Physician Payment Committee of the American College of Emergency Physicians (ACEP). I appear today on behalf of the more than 12,000 members of ACEP. I am accompanied by Thomas Nickels, Director of the College's Washington, D.C. office. The College appreciates this opportunity to comment on various aspects of the upcoming annual report to Congress from the Physician Payment Review Commission (PPRC).

Relative Values and a Medicare Fee Schedule

Mr. Chairman, emergency medicine was not among the 18 specialties included in the first phase of the Harvard Resource-Based Relative Value Scale (RBRVS) study completed last fall. However, emergency medicine is among the specialties that are now being examined in the second phase of the project. Overall, ACEP believes that the Harvard RBRVS project represents a major contribution to the development of a relative value scale for physicians' services that more accurately reflects the actual inputs needed to produce such services.

We further believe that the Physician Payment Review Commission has proposed some important modifications to the Harvard methodology that make it feasible to use a resource-based relative value approach to Medicare payments for physicians' services. On the basis of these modifications, the PPRC has recommended that Medicare's current usual, customary and prevailing payment system for physicians' services be replaced with a fee schedule that is based primarily on resource costs. ACEP supports this recommendation. The work at Harvard and the research by the Commission clearly show that physician evaluation and management services are systematically undervalued when compared with most other physicians' services provided to patients. Most of our activities consist of these kinds of services. This finding is of particular interest to emergency physicians who have the responsibility to react quickly and decisively in assessing and dealing with the serious nature of medical problems treated in the emergency department. In effect, patient evaluation and management at these critical moments are what encompasses the practice of emergency medicine.

While resource costs have received most of the attention in discussions about ways to establish a more rational and equitable Medicare payment system, the importance of some services relative to other services has been recognized by Congress in an additional way. Based on recommendations from the Commission, changes have been enacted to redress some of the current payment imbalances for primary care services, including emergency department visit services. The issue of special recognition for primary care services at present arises because more time will be needed before a new Medicare payment system based on resource costs can be implemented. We hope this Subcommittee will continue to recommend differential treatment for primary care services, including emergency department visits, in connection with any payment actions taken by Congress on an interim basis.

Fee Schedule Implementation

We have some concerns, Mr. Chairman, about the PPRC's recommendations to move rapidly with implementation of a Medicare fee schedule in 1990 leading to full implementation by 1992. It seems to us that there is still much more to be learned before major revisions in payment rules are adopted by law.

We recognize, of course, that the Congress is anxious to approve a better approach to physician payment than now exists. However, the impact on both beneficiaries and physicians of some of the proposed changes recommended by the Commission, is not very clear at this time, but could be significant. Our own specialty participation in the Harvard study, for example, is only just beginning, and more time may be needed to develop the data and analysis needed for all specialties before a workable fee schedule can be adopted. It is also essential that changes of the magnitude proposed be based on information -- in addition to relative value calculations -- that is both accurate and current, especially in the case of physician cost of practice data. We urge that Congress be mindful of these considerations in judging the appropriate timing of physician payment reform initiatives.

Defining Physicians' Services

Mr. Chairman, the Commission has concluded that reforms in the coding and definition of physicians' services are needed in order to implement a fee schedule based on resource costs. One of these reforms involves improvements in the current codes used for evaluation and management services -- commonly referred to as the visit codes. Results from the Harvard study suggest that there are problems with the current codes used by physicians to accurately reflect their work effort because the levels of service are not precisely defined. Interpretations of the visit codes varies widely, not only by specialty and geographic location, but also among individual physicians.

ACEP agrees with the PPRC that there are serious problems with the use of the current codes in defining physician work, and that there are particular problems with some of the codes for emergency department visits. We also agree with the Commission that the ambiguity inherent in the current codes could create serious problems with valuing and paying for services in a fee schedule.

As we understand it, however, the Commission is now recommending that the coding system be revised so that time would be used as a significant factor in establishing different levels of service -- and, presumably, therefore, different relative values for these services, as well. Such a recommendation may be appropriate for some physician specialties, but we believe there is a unique difficulty with linking the valuation of emergency services to time. Many emergency services and procedures need to be provided quickly, and their value lies in their quick application. Often, the longer it takes to provide a service in an emergency, the lower the value to the patient.

ACEP believes that the value of emergency department visit services should be more closely linked to such factors as knowledge, skill, effort and stress, and not disproportionately to time. We have communicated our views about the special problem of using the time factor in emergency settings to the staff of the Commission and to Harvard researchers looking at the services provided by specialists in emergency medicine. The College has also recently completed its own review of coding issues involving emergency department services, and intends to share its recommendations with the PPRC and with officials of the Health Care Financing Administration as soon as possible.

Target Expenditures

Mr. Chairman, one of the major recommendations from the PPRC calls for approval of a national target expenditure plan for physicians' services under Medicare. More specifically, the Commission recommends beginning with a single target at the national level, but anticipates that the policy could evolve into one with multiple geographic or specialty-specific expenditure targets.

ACEP opposes this recommendation in its current form for a number of reasons, but primarily because it fails to recognize the nature of the demand for emergency services by the Medicare population. Among other things, the theory behind a target expenditure plan is to establish incentives to limit expenditures for physicians' services that take into account both the volume and the price of the services provided. Emergency physicians, however, do not determine, nor can they control, the number of patients who present to emergency departments of hospitals. Moreover, from a public policy standpoint, ACEP strongly opposes any steps that would tend to discourage any patients from seeking needed emergency care when they are acutely ill or believe they need urgent medical attention.

Thus, the idea of establishing an expenditure target for emergency services -- as part of an overall scheme or under a multiple target plan -- could be problematic. For one thing, we do not see how such expenditures could be reasonably predicted in advance. If, however, Congress decides to adopt an expenditure target plan, Congress should direct that emergency services be excluded from the plan.

Medicare Assignment

Finally, Mr. Chairman, I would like to share the College's views about the need for improvements in Medicare's assignment procedures. We believe that major payment reform changes should not be undertaken without careful consideration of the financial implications of those changes on patients.

Mr. Chairman, ACEP is pleased to note, following a detailed examination of Medicare Part B claims data, that emergency physicians appear to have the highest assignment rates of all physicians who provide services to patients under the Medicare program. For example, our study of Medicare data on emergency department visit codes shows that assignment is taken on about 90 percent of all claims. There may be several reasons why the assignment rate is not even higher than this, the most important of which has to do with the unreasonably low amounts paid by some Medicare carriers for patient management and evaluation services in general, and for emergency physicians' services in particular.

We understand that the Commission has, in principle, endorsed the need for making changes in Medicare's assignment policy where beneficiaries have no meaningful choice of provider, including in emergency circumstances. We would also point out, however, that unlike other practitioners, emergency physicians have no choice in the selection of which patients they will treat. In fact, it has long been the position of the College that no patient coming to the emergency department should be denied emergency medical care. I would further add that Federal law also requires that all patients be examined and treated as if they have potentially life-threatening or other serious illnesses or injuries. In other words, we believe we have an ethical, moral, and legal responsibility to evaluate, and where needed, to treat all patients presenting to the emergency department.

Since patients who present with emergencies have no meaningful choice of provider, and, since the emergency physicians who treat them really have no choice in the selection of which patients they will treat, we agree that Medicare's current assignment rules should be changed under a new Medicare fee schedule. And if, as part of this reform process, payments for emergency physician services are reasonably valued and paid appropriately, the American College of Emergency Physicians is prepared to support the acceptance of such payment levels as payment in full -- thereby relieving Medicare patients of balance billing obligations. We intend to meet with the Commission to explore this matter further.

Thank you, Mr. Chairman, for this opportunity to testify. I would be pleased to answer any questions you or your colleagues may have.

Chairman STARK. Thank you, Dr. Bishop. Dr. Arens, are you next?

Dr. ARENS. Yes.

STATEMENT OF JAMES F. ARENS, M.D., PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Dr. ARENS. Mr. Chairman, I am Dr. James F. Arens, professor and chairman of the Department of Anesthesiology at the University of Texas Medical Branch at Galveston and president of the American Society of Anesthesiologists, representing more than 26,000 physicians. I am pleased to express ASA's views on the PhysPRC report and the administration's budget proposals.

Certainly we consider the ASA relative value guide [RVG] to be the best measurement of anesthesia services and are pleased that both Professor Hsiao and PhysPRC agree. We are pleased that PhysPRC plans to use the longstanding ASA RVG rather than developing a new one. PhysPRC also finds significant problems with the cross-specialty links for anesthesiology, and we will work with them on developing reasonable links.

PhysPRC discussed patient choice issues and rejected a prohibition on balance billing for select physicians. To target anesthesiologists as radically different from other physicians as to assignment rates, balance bills, or lack of patient choice appears without foundation.

Although Medicare has long required that anesthesiologists be reimbursed using a relative value guide system, the carriers have used many different guides. ASA worked with the Congress to solve this, and OBRA 87 mandated a uniform RVG.

ASA supports HCFA's recent adoption of the 1988 ASA RVG as the uniform Medicare guide, but we strongly oppose its decision to eliminate physical status modifiers, which quantify the severity of illness for each patient.

The RVG frequently results in automatic savings to the Medicare Program. With improved techniques, surgical and anesthesia times are reduced, and this is reflected in the total anesthesia charge, both to Medicare and the patient.

Also, base units may be reduced over time. Consider pacemakers, which used to be implanted through an open chest wall requiring 2 to 3 hours of time. Pacemakers are now inserted through a vein in an hour or less. Because of these changes, ASA reduced base units from 20 to 4; time units from 12 to 4.

In recent years, anesthesiology has absorbed targeted cuts exceeding $100 million a year. Recent reductions include:

Medical direction has been limited to no more than four concurrent procedures which in 6 years has saved $331 million.

Base units for anesthesia for cataract surgery have been reduced. In 5 years, savings of $405 million were achieved.

Base units for concurrent medical direction have been reduced, with a 4-year saving of $70 million.

Let me note that using the RVG, reductions to anesthesiologists cannot be passed on to patients. For example, with the percentage reductions for concurrent medical direction of nurse anesthetists, the lost base units cannot be balance billed, and the beneficiary is therefore protected.

Now, with regard to the administration's proposals, ASA opposes the 8 percent across-the-board reduction. Secretary Sullivan testified, mistakenly, that the PhysPRC has identified anesthesiology as overpriced.

There has been no such finding in the commission's report. In fact, the report did not even forecast anesthesiology fees. If the Secretary is assuming that anesthesiology will likely be a loser under the RVS, then global reductions should be addressed by PhysPRC.

It is unacceptable to preempt that process now with random cuts and identify the entire work of a specialty as overpriced. The administration has done no analysis which finds conversion factors inappropriate.

ASA opposes new reductions in medical direction payments. OBRA 87 mandated cuts in medical direction payments for concurrent procedures which reduced the base units by a sliding scale. Because of congressional concerns about this provision, the GAO is studying its impact. That report is not due until April 1990. There should be no revisions to current law until this study is reviewed.

The fiscal year 1990 proposal is radically different from OBRA. It would not only increase the reductions but would apply those reductions to the total charge—base and time units.

In effect, the administration's proposal means a 30- to 50-percent reduction for most anesthesiologists. These cuts would have far-reaching impacts, and there is no question they would destroy the anesthesia care team because of the overwhelming economic disincentives for anesthesiologists to work with nurse anesthetists.

Seventy percent of anesthesiologists work with CRNA's in the care team mode. Further, nurse anesthetists are required by State law to practice under direct medical supervision. They would be displaced from traditional practice arrangements. The result would be severe impairment of patient access to care, especially in rural areas.

We would like to say we also support our relative value guide being used in the context of the RBRVS. However, we are at the present time working with both Professor Hsiao and PhysPRC because for our specialty, we have major problems with the cross links, which make no sense for our specialty.

Second, we would support the income related assignment, but we are opposed to mandatory assignment for anesthesiology because of the great disparity between our prevailing and our MAAC charges.

Third, we are opposed to the concept of expenditure targets but, like the others, we support practice guidelines, and we will continue to bring our best efforts forward to come up with additional standards of care, as we have in the past 4 years.

While opposing the administration's proposals, ASA believes there are reasonable ways to produce Medicare savings that are equitable to both beneficiaries and physicians. ASA is willing to work with the Congress on both immediate savings and long-term reform. Thank you.

[The statement of James F. Arens, M.D., follows:]

STATEMENT OF THE
AMERICAN SOCIETY OF ANESTHESIOLOGISTS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
April 17, 1989

I am Doctor James F. Arens, Professor and Chairman of the Department of Anesthesiology at the University of Texas Medical Branch at Galveston. I am President of the American Society of Anesthesiologists (ASA), representing more than 26,000 physicians nationwide, and I am pleased to be here today to express ASA's views on the President's Fiscal 1990 budget proposals and on the soon to be released annual report of the Physician Payment Review Commission.

Relative Value Guide

Anesthesiologists have been reimbursed on the basis of a relative value system since before the enactment of Medicare, and ASA published its first Relative Value Guide (RVG) in 1962. Even though ASA has previously testified before this Subcommittee regarding the RVG, the Guide is so important both as the framework for budget reductions and a precursor of the Hsiao/PPRC Resource Based Relative Value Scale (RBRVS), that I would like to highlight its methodology and use.

In its simplest form, the RVG is developed by assigning to each distinct surgical procedure or service a unit value, based on the complexity, effort and resources associated with the procedure. In this way, a table or scale is constructed for a series of procedures or services to which are assigned individual unit values demonstrating the relative complexity of each. These are the base units. For example, in the 1988 ASA RVG, there are 20 base units assigned to cardiac bypass grafts, compared to 4 base units for hernia repairs. Because our Guide and the related CPT-4 codes are broad (there are 250 anesthesia codes for the 6,000 surgical codes), new codes are rarely needed when new technology is introduced. This, in turn, means there are relatively few new services in anesthesiologists' reimbursement.

Time is the essential element in determining the level of anesthesia service for each individual patient and can vary substantially according to each patient's circumstances. Because time is so essential to anesthesia practice, the ASA RVG adds time units; Medicare recognizes one unit per each fifteen minutes of anesthesia time for anesthesiologists providing care directly and one unit per each thirty minutes of anesthesia time for anesthesiologists providing medical direction services.* Anesthesia time is defined as beginning when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ending when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision.

ASA regards the time factor as enormously important in providing a fair and accurate measurement of the anesthesiologists' services. As acknowledged by the Hsiao study it is the surgeon, not the anesthesiologist, who controls time. Further, an extensive study by Battelle Memorial Institute disclosed a high and stable correlation between surgical time and anesthesia time; operating room and recovery room records yield easy verification of anesthesia time.

I also would like to note that anesthesiologists do not charge beyond the base units for pre-operative and post-operative time spent in evaluating and caring for the patient. Even though complex procedures invariably require a detailed, time-consuming pre-operative evaluation, it is still accounted for by the base units.

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* Prior to implementation of a Part B payment system for certified registered nurse anesthetists (CRNAs) on March 1, 1989, Medicare recognized: one time unit per each 15 minutes of anesthesia time for anesthesiologists medically directing their employee-CRNAs; and one time unit per 30 minutes of anesthesia time for anesthesiologists medically directing hospital-employed CRNAs.

The ASA RVG also uses physical status modifier units to quantify the medical condition of each patient. The administration of an anesthetic to a patient with severe concomitant systemic disease simply carries a higher risk and requires greater skill than does peforming the same procedure on a healthy patient. Research indicates that it is the physical status of the patient, not the surgery or anesthetic, which is the best predictor of surgical outcome.

The RVG, then, describes and measures anesthesia care provided to individual patients. To establish a charge based on the RVG, a dollar conversion factor is applied. Each anesthesiologist has three conversion factors: the Medicare prevailing conversion factor, which is the amount recognized by the carriers for all anesthesiologists in an area; the discounted MAAC conversion factor, which is the individual anesthesiologist's 1984 frozen actual charge with appropriate MEI updates; and the non-discounted conversion factor charged to non-Medicare patients or commercial carriers.

OBRA 87: Uniform RVG

Although Medicare has for some years required that anesthesiologists be reimbursed using the RVG methdolology, the 54 carriers have not been required to use a specific guide. Section 4048 of the Omnibus Budget Reconciliation Act of 1987 mandated that HCFA establish a uniform RVG for reimbursement of anesthesia services under the Medicare program. Section 4048 was inserted into OBRA 87 at the urging of ASA and was strongly supported by ASA in the course of its consideration by Congress.

ASA clearly supports HCFA's proposed regulation adopting the 1988 ASA RVG and the associated CPT-4 anesthesia codes for services provided after March 1, 1989. We remain opposed to HCFA's proposal to eliminate recognition of physical status modifier units from the uniform RVG recognized by Medicare. Modifiers as measures of individual case severity are an integral part of the ASA RVG; to eliminate them is to adopt an incomplete RVG, one which in essence will distort the measurement of care rendered to many patients.

In light of the Physician Payment Review Commission's support for incorporating severity of illness measurements in the Harvard Resource Based Relative Value Scale, and Dr. Hsiao's indication that the ASA system could be a model, HCFA's proposal does not make sense.

RVG As a Framework for Savings

The RVG methodology frequently results in "automatic" savings to the Medicare program. With improved surgical techniques and familiarity with procedures, anesthesia time is often reduced. When this happens, the number of reported time units is also reduced, automatically resulting in a reduction of the total charge, both as recognized by Medicare and to the patient. Similarly, the anesthesia risk and complexity base units may be reduced over time. A prime example of decreased charges resulting from use of the RVG is seen in the case of pacemaker implantation. Previously implanted through an open chest requiring two to three hours of anesthesia time, pacemakers are now inserted through a vein in an hour or less. Because of these procedural changes, ASA reduced the base units from 20, to 15, to 4; time units decreased from 12, to 4.

The ASA RVG is not a static document, but one which is reviewed each year and through ASA House of Delegates' action, changes are approved. The 1988 RVG reduced base units for seven procedures; none were increased. Again, when such revisions reduce base units, there are savings to the Medicare program, commercial carriers, and all patients.

Congressional and Administrative Action

In recent years, anesthesiology has absorbed targeted Medicare cost reductions exceeding $100 million per year. Recent reductions achieved within the framework of the RVG include:

- 1983 -- Reimbursement for medical direction of CRNAs is limited to no more than four concurrent procedures. Six-year savings: $331 million.

- 1986 -- Reduction in reimbursement for anesthesia services for cataract surgery from 8 base units to 4 base units. Five-year savings: $405 million.
- 1987 -- Reduction in base units for concurrent medical direction of CRNAs. Four-year savings: $70 million.

ASA has always supported policies ensuring that any Medicare reductions to anesthesiologists not be passed on to the beneficiaries, and this is simple to do within the context of the Relative Value Guide. Indeed, when the new CRNA Part B fee schedule -- which halved the time unit reimbursement for anesthesiologists who medically direct their own employees -- was implemented, ASA asked HCFA to revise the draft Medicare Carrier Manual instructions to clearly state that the "lost" time units could not be balance billed. Similarly, with regard to the sliding scale percentage reductions for concurrent medical direction of CRNAs, the "lost" base units cannot be balance billed to the patient. Medicare reductions aimed at anesthesiologists should be absorbed by anesthesiologists, not Medicare patients. As illustrated by these two cuts, the RVG methodology assures this outcome without imposition of special MAACs which amount to mandatory assignment.

FY 90 PROPOSALS

The Administration's budget proposes:

- Eight percent across-the-board reductions in reimbursement for surgery, anesthesiology and radiology services.
- Further payment reductions in concurrent direction services of two or more nurse anesthetists. The budget proposes increased cuts to 30 percent for two concurrent procedures; to 40 percent for three concurrent procedures; and to 50 percent for four concurrent procedures -- and applies this further reduction to both base and time units.

ASA strongly opposes both these proposals.

ASA opposes the 8 percent across-the-board reduction proposal as totally unjustified.

In his statement to the Budget Committee, DHHS Secretary Louis Sullivan said: "For certain specialties and procedures that the Physician Payment Review Commission has identified as overpriced, the budget proposes to reduce payment levels in a graduated fashion, ranging from a 12 percent reduction for a number of selected procedures, to an 8 percent reduction for radiology, anesthesiology and surgery services."

There are several problems with this statement.

ASA does not understand the Administration's linkage of reductions in physicians' payments for specific procedures identified as "overpriced," with across-the-board cuts to an entire specialty, regardless of the procedure involved. There is nothing "graduated" about the 12 percent and the 8 percent -- the concepts are completely unrelated.

ASA takes issue with the Administration's statement that PPRC has identified anesthesiology services as "overpriced." There has been no such finding in the Commission's report; in fact, the PPRC RBRVS simulation model did not even forecast anesthesiology fees. Perhaps the Secretary is basing his assessment of anesthesiology on the assumption that the so-called procedural specialties will likely be "losers" under the RBRVS. If that occurs, then any reductions should be addressed by PPRC within the framework of the RBRVS. To preempt that process with random cuts now is unjustified.

The justification for an across-the-board cut is undocumented. We have discussed the construction of a charge using the RVG and a conversion factor. HCFA has just adopted uniform base units, thereby deeming them to be accurate and reasonable. The Administration has done no analysis indicating that conversion factors are inappropriate. In fact, congressional concerns have been focused on the problem of states or areas with already low reimbursement. Across the board cuts will cause disproportionate harm in many under-reimbursed states.

Part B payments to anesthesiologists (about 4 percent of the nation's physicians) represent about 5 percent of all Part B payments, or about $650 million currently. This percentage has remained fairly constant since 1975. Further, according to the General Accounting Office, increases in the average Medicare payment per enrollee for anesthesiology services mirrored those of other physicians in the years 1975 to 1985. There is simply no evidence that anesthesiologists' costs per enrollee are unusual. A punitive 8 percent cut is not indicated.

The budget also proposes to radically revise reductions to anesthesiologists providing medical direction to certified registered nurse anesthetists (CRNAs) in concurrent procedures.

ASA opposes reformulated reductions in medical direction payments as unfounded and devastating to the anesthesia care team mode of practice.

OBRA 1987 mandated cuts in medical direction payments for concurrent procedures which reduced only the base units by 10 percent in the case of two procedures; 25 percent in the case of three procedures; and 40 percent in the case of four procedures. ASA was willing to support this provision within the context of the 1987 reconciliation process. There were, however, some congressional concerns about this provision, so OBRA 87 mandated that the GAO study the impact of its implementation; that report is not due to the Congress until April 1990. Revisions to current law should not be considered until this study is received and reviewed.

The FY90 proposal is radically different from the OBRA 87 language as it would not only increase the reductions to 30 percent, 40 percent and 50 percent, respectively, but would apply those reductions to the total charge (base and time units). Such severe cuts would cause overwhelming disincentives for anesthesiologists to practice with nurse anesthetists. Further, when such reductions are applied to the total charge the result is that the prevailing and MAAC conversion factors are reduced by the cited percentages. In effect, then, the Administration's budget proposes across-the-board reductions for most anesthesiologists of 30 to 50 percent. If enacted, these cuts would have far-reaching impacts and will almost certainly result in decisions by anesthesiologists not to provide medical direction to nurse anesthetists:

- 70 percent of the nation's anesthesiologists currently provide care working with CRNAs as an anesthesia care team. The economic disincentives imposed by these cuts would force many anesthesiologists to abandon this needed mode of care.

- CRNAs, required by state and federal law to practice with medical direction, will be displaced from traditional practice arrangements.

- The result of these dislocations will be that patient access to care, especially in rural areas, will be severely impeded.

While opposed to the Administration's proposals, ASA recognizes the substantial deficit reduction pressures that Congress faces this year in order to comply with the Gramm-Rudman law. ASA believes there are more reasonable ways to produce Medicare savings this year that are equitable to both beneficiaries and anesthesiologists. As in the past, ASA is willing to work with the Committee on both immediate budget deficit reduction and longer-term reform.

PPRC REPORT

The Subcommittee recently heard testimony from Dr. Philip Lee, Chairman of the Physician Payment Review Commission (PPRC) and will soon receive its Annual Report to Congress. The report presents the PPRC's recommendation that an RBRVS be finalized, with phased-in implementation to begin in 1990. PPRC also recommends increased funding for the development of practice guidelines and standard setting.

With ASA's history of RVG development and the historical use of a relative value system by anesthesiologists, it is not surprising that we are strong supporters of this system. ASA was an active participant in the Hsiao RBRVS study. While ASA and others will disagree with reductions in reimbursement which could result from the RBRVS, the concept is sound and we believe its adoption likely. Implementation of the RBRVS for all of medicine would bring a dramatic change in physician reimbursement. If the Congress chooses to implement the RBRVS, then, as PPRC has noted, the cooperation of physicians will be required to make it work. ASA believes the American Medical Association must play an important role in the still-needed refinements of the RBRVS and in maintaining physician cooperation. As we seek our specific refinements, we will continue to work with Dr. Hsiao, the AMA, PPRC, and ultimately the Congress.

Certainly, we consider the ASA RVG to be the best existing measurement of anesthesia services, and are gratified that both Dr. Hsiao and PPRC agree. The PPRC report accurately describes the ASA RVG as a system which bases payment on time, the difficulty of the operation and the patient's condition. We understand the report will state that since the ASA RVG is resource-based and has been in use for a long time, the Commission plans to consider it as an alternative to developing new values. ASA will continue working with PPRC on retention of this accepted methodology within any new system.

The PPRC recognizes that there are significant problems with the Hsiao cross-specialty links for several specialites, including anesthesiology. Other physicians simply do not perform the services provided by anesthesiologists; Hsiao terms anesthesiology an "insular" specialty. We cannot accept, or even understand, the cross-specialty links: there are only five links made for anesthesia services, loosely tied together by intra-service time. For example, the anesthesiologist's consultation for a transfusion reaction in a patient with abrupt onset of fever and back pain is linked to an allergist's conference with a patient or family. The transfusion reaction consultation is not common in practice, and would not occur as an independent activity, but would be related to an ongoing procedure.

The cross-links are critical to the RVS outcome because they determine where a specialty is placed vis-a-vis other specialties on the common scale. ASA will also be working with the PPRC on developing reasonable cross-links.

Beneficiary Choice and Balance Billing

The assignment rates for anesthesiologists have increased significantly over the past five years. ASA understands that information (based on an 8-state survey) presented to PPRC by its staff and consultants shows a 70 percent assignment rate for anesthesiologists; other physicians appear to be closer to 80 percent.

One reason for a lower assignment rate is that anesthesiologists receive markedly less "on the dollar" from Medicare than do other specialists. According to data from HCFA and PPRC, the Medicare prevailing charges for anesthesiologists is 40 to 50 percent less than the anesthesiologists' MAAC charges; the reduction rates -- that is, the difference between the prevailing and the MAAC -- for other specialties do not approach this disparity.

Anesthesiologists do not have access to the same financial information about the patient as does the referring physician. Unfortunately, the discussion of the patient's financial situation frequently comes after the bill has been sent and it becomes apparent that the patient is financially unable to pay. In such a situation, many anesthesiologists will then write-off the patient's bill, but because of the time at which the write-off occurs, the transaction does not appear in the system as an assigned claim.

It makes sense that patients are generally sicker, using more intensive services and accruing greater charges when anesthesia services become a factor. In fact, anesthesiologists' services do not become significant until the patient is in the 95th percentile of Medicare-approved charges per individual. The combination of intensity of service and Medicare reimbursement amounts lagging 40 to 50 percent below charges, account for anesthesia balance bills representing about ten percent of balance bills.

ASA has also indicated to the PPRC and the Congress that we would support an income-related assignment system. This would be an equitable method to assure those in financial need receive consideration, while those able to pay the already-discounted MAAC charge would do so.

The argument has been made that anesthesiologists should have special assignment rules because the patient generally does not select the anesthesiologist, i.e., the opportunity to shop for a participating physician is not available. ASA believes this is an extremely weak argument. Patients rarely select beyond their primary care physician; it is the primary care physician who refers patients on to their choice of surgical specialist, cardiologist, oncologist, etc. In many other situations, the choice is made by the hospital, clinic, managed care system, or by a specialist who is already once removed from the primary care physician.

ASA understands that the PPRC Report will indicate that the Commission considered, but rejected, a prohibition on balance billing for select physicians, including anesthesiologists. The PPRC apparently agrees that the definition of limited choice physicians is not clear cut. Further, PPRC would prefer to assess the impact of its recommendation concerning universal limits on balance billing that will be associated with the RBRVS and fee schedule. ASA supports the PPRC's decision not to recommend different treatment for certain specialists.

To target anesthesiologists as radically different -- as to assignment rates, balance bill liability or lack of patient choice -- appears without foundation.

In past years, this subcommittee has recognized that anesthesiologists are not in a position to influence volume. However, there is a related issue with which we have dealt: if we cannot control the number of anesthesiology services being provided, we can address the quality and performance of each service. In other words, we can seek to assure that anesthesiologists provide the services that are being reimbursed.

ASA was the first specialty to set national standards and has adopted four to date: Basic Standards for Preanesthesia Care; Standards for Basic Intra-Operative Monitoring; Standards for Postanesthesia Care; and Standards for Conduction Anesthesia in Obstetrics. The most important role of standards is to improve patient safety, but they also can tell the patient and insurer that they have received what they paid for.

Regarding several of the other specific recommendations contained in the PPRC Report, ASA makes the following comments:

- **Recommendation: Premiums for liability insurance should be integrated into the RVS through a separate practice cost factor.** The medical liablity crisis continues to be out of control. Anesthesiologists have gained some relief in premiums due to the standards set by ASA and other risk management initiatives. ASA supports the intent of PPRC's recommendation: 1) separate consideration of the liability factor will help show the unacceptable costs; and 2) there will be consideration of both geographic and practice differences.

- **Recommendation: Fee schedule payments should vary geographically.** ASA supports valid geographic cost of practice variations.

- **Recommendation: A uniform policy on the delineation of carrier charge localities is needed.** Carrier variations, both as to coverage decisions and payment rates, follow no clear pattern. Any improvement of the charge area boundaries would be a step toward uniformity in the program.

- **Recommendation: A transitional stage should begin in 1990, with implementation of the full Medicare Fee Schedule planned for 1992.** Although ASA is pleased that its RVG is being considered as an alternative to development of new values, the specialty of anesthesiology has not been fully considered by either Hsiao or PPRC. Without knowing the outcome, ASA cannot support a 1990 implementation of the RBRVS, and suggests 1991 as a more reasonable date. Considering the overwhelming changes the RBRVS will bring to all of medicine, we believe it is worth taking the time to do it correctly.

ASA further strongly recommends at least a three-year transition period to the fee schedule. The disruption to physicians and patients of a relatively abrupt transition would undermine the reforms and discourage the needed physician cooperation.

- **Recommendation: A national expenditure target should be used to determine annual conversion factor updates under the fee schedule.** ASA has two comments with regard to expenditure targets. First, within the context of the PPRC report, we must say that until the RVS conversion factors are known, it is difficult to assess the impact of expenditure targets. Further, the concept of seeking to exert peer pressure among 500,000 physicians to meet a national target is an unrealistic approach to controlling volume.

Secondly, ASA is opposed to taking any of the PPRC recommendations out of the context the Commission intended. There will certainly be debate about expenditure targets, but that debate should be associated with refinement of the RBRVS and development of the conversion factor(s). ASA believes discussion of such targets is premature, inappropriate under the current reimbursement system, and we would oppose their imposition.

Chairman **Stark**. Thank you.

Dr. Sharfstein.

STATEMENT OF STEVEN S. SHARFSTEIN, M.D., FORMER DEPUTY MEDICAL DIRECTOR, CHAIRMAN OF THE BUDGET COMMITTEE, AND MEMBER OF THE WORK GROUP ON RESOURCE BASED RELATIVE VALUE SCALE OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Dr. **Sharfstein**. Thank you, Mr. Chairman and distinguished members of the committee. My name is Steven Sharfstein. I am executive vice president and medical director of Shepherd Pratt Hospital, a nonprofit private psychiatric hospital in Baltimore, MD. Formerly, I was deputy medical director of the American Psychiatric Association.

I currently practice psychiatry, and I engage in a variety of research on the financing of health and mental health services. You have my statement for the record, and I will be brief. I would like to make some comments on the Medicare psychiatric benefits, the Harvard RBRVS study, quality assurance and peer review, in particular, the American Psychiatric Association's national model for specialty-sponsored quality assurance and peer review and selected PhysPRC recommendations.

On the Medicare psychiatric benefit, this committee worked hard to improve the psychiatric coverage, but there are still significant limitations on the coverage for patients with metal disorders.

Some services are exempt from a variety of caps, but much outpatient care still has an effective 50-percent copayment and an annual dollar limitation of $1,100. There is, in addition, the 190-day lifetime limit per beneficiary lifetime in a psychiatric hospital. I think we are very anxious to see what can be done to make the copayments equivalent for medical and all psychiatric services. As you can see, we already have significant expenditure targets for psychiatry at present.

Psychiatry's portion of the Harvard relative value study was funded by a special contract with NIMH. The APA believes the study's emphasis on supportive, cognitive, assessment, management, and caring activities is congruent with our views.

The analysis of the preliminary report submitted to HCFA and subsequently to the NIMH suggests that there are significant problems in the report for psychiatry which are unlikely to be addressed without a refinement of the psychiatric RVS. Therefore, NIMH is in the process of finalizing a contract for this particular refinement.

There were three major problems. There were problems identified in the measurement of work. There were problems identified with the coding, and there were some problems with the practice costs.

Now with regard to the APA's quality assurance and peer review, I think we are unique among medical specialties in that we have provided a peer review and quality assurance program for 10 years for our members and for a variety of insurance carriers.

We have retrospectively reviewed hospital cases for the CHAMPUS Program and for private insurance carriers. We have reviewed almost 200,000 cases retrospectively, the majority for CHAMPUS.

Prospectively we have reviewed 50,000 inpatient cases using national practice guidelines for admission certification and discharge planning. This review has saved as much as 40 percent for some companies and on average has saved 21 percent. I think that the fact that we have been under the gun in terms of benefit limitations in the private health insurance and the various limits of Medicare has helped us to build practice guidelines into our portfolio. I think we are much ahead in this particular area.

We do think that in terms of the PhysPRC recommendation for implementation of an RVS, that psychiatry's RVS should be delayed due to the refinement being conducted by NIMH. We think that implementation of expenditure targets at this point would be inappropriate for us since we are already under quite a few expenditure targets.

So in summary, I don't think that we should include psychiatry yet under the RBRVS until we have the revised study. I appreciate the opportunity to speak before the committee, and I am prepared to answer any questions. Thank you.

[The statement of Dr. Sharfstein follows:]

STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Mr. Chairman and distinguished Committee members, I am Steven S. Sharfstein, M.D., Vice President and Medical Director of the Shepherd and Enoch Pratt Hospital in Baltimore, Maryland and Clinical Professor of Psychiatry at the University of Maryland. In addition, I am Chairman of APA's Budget Committee and a member of its Work Group on the RBRVS. Formerly, I was Deputy Medical Director of the American Psychiatric Association and was involved in health policy and health financing research at the National Institute of Mental Health. In addition to the practice of psychiatry, much of my career has been devoted to health financing and services research. I appear before you today on behalf of the American Psychiatric Association, a medical specialty society representing more than 35,000 psychiatrists nationwide, to discuss issues specific to psychiatry as consideration is given to physician payment reform under Medicare and other budgetary concerns.

In my testimony today, I will review for you APA's analysis of the Harvard Resource - Based Relative Value Study, some concerns we have about areas of the Physician Payment Review Commission's recommendations to Congress as well as some of the positive recommendations. Prior to beginning the discussion of the reaction to some of the proposals, I will also review once again some of the limitations for patients with "Mental, Psychoneurotic, and Personality Disorders". These limitations were changed for the first time in OBRA 87 due to your fine work and the work of many members of your subcommittee.

MEDICARE COVERAGE FOR "MENTAL, PSYCHONEUROTIC, AND PERSONALITY DISORDERS"

The Medicare program outpatient benefit for patients with mental disorders was limited to an arbitrary $250 (after an effective 50% copayment) from the inception of the Medicare program until the recently approved changes included in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203). A special exception was made administratively in 1984 by exempting medical management of Alzheimer's disease and related disorders from caps imposed on psychotherapy.

The changes made in OBRA raised the dollar limitation that Medicare pays per annum to $1100 (after an effective 50% copayment) over a two year period. Beginning in January of 1989 psychiatrists' outpatient services for "monitoring and changing drug prescriptions" are exempt from the dollar limitations and will be paid at the same 80/20 copayment rate as other physician services. This particular benefit is complicated for beneficiaries and carriers to understand. The proposed regulations and instructions implementing the drug management benefit will hopefully be issued shortly. The passage of these benefit changes was a significant step on the legislative journey toward non-discrimination and we thank your committee for its fine work in accomplishing this change.

Diagnostic service charges and physician fees in a hospital for patients with mental disorders have always been treated like all other physician services and paid at the 80/20 copayment rate. Unfortunately, despite significant strides in the treatment of mental disorders, patients still are subject to serious discriminatory and arbitrary limits under Medicare in payments for the treatment of their mental disorders.

Treatment in a psychiatric hospital is also constrained to a 190 day limit per a beneficiary's lifetime. These benefits may have reflected treatment patterns in the early 1960's, but do not now reflect current treatment patterns. As you know, expenses incurred for services furnished by other health personnel in conjunction with "or incident to" a physician's treatment of mental, psychoneurotic or personality disorders are not subject to the dollar limits on psychiatrists' treatment services. Thus, additional services may be provided in a variety of settings incident to the psychiatrists' services.

HARVARD RESOURCE-BASED RELATIVE VALUE STUDY (HRBRVS)

Psychiatry participated in the HRBRVS study from its beginning. Our segment of the study was funded by NIMH. APA believes that the approach of the Harvard RBRVS is a thoughtful and useful one. The study's emphasis on supportive, cognitive, assessment, management and caring activities is congruent with our views. Analysis of the preliminary report submitted to HCFA suggested that there were significant problems in the results for psychiatry which were likely to require another survey. The final results of the preliminary report for psychiatry will be submitted to NIMH shortly.

While clearly the Harvard study was an enormous task, expertly undertaken, there are areas which could be stengthened with additional data. On January 17, 1989 the National Institute of Mental Health issued a request for a proposal for a "Refinement of the Development of a Resource-Based Relative Value Scale for Psychiatric Services". A contract for this refinement is in the process of being finalized with Harvard.

APA's initial analysis of the Harvard study noted difficulties with the measurement of work; CPT codes for our services; and the measurement of practice costs. Many of these areas of difficulty were also identified by the Harvard researchers and our concerns have also been noted by the PPRC.

Measurement of Work

The APA Work Group identified three problems with the measurement of work that are likely to affect the final RBRVS for psychiatry.

- The vignettes are not representative of practice. Severe cases, such as management of a psychotic or suicidal patient, were not included among the vignettes. In addition, hospital cases — often among the most severe patients — are underrepresented. Clinician members of APA's Work Group on the RBRVS believe that some of the vignettes are ambiguous. In fact, Dr. Hsiao found that the degree to which psychiatrists agreed on their ratings of various services was the lowest of all specialties.

- The standard vignette for psychiatry is toward the low end of the scale — only one fifth of the vignettes had ratings of work below the standard.

- Pre- and post-service work measurement has been described by many as a weak component of the RBRVS because values are based on limited data and challengeable assumptions. For psychiatry, there is a particular problem because pre- and post-service time for 11 psychiatry vignettes were set equal to the time for one vignette. Clinician members of the APA work group felt these services, in fact, entailed different amounts of pre- and post-service time.

CPT-4 Codes

Problems with the CPT-4 codes for psychiatry limit the accuracy of the RBRVS values. The two major coding problems affecting the results of the RBRVS are described below along with other coding issues.

- Mapping Vignettes to CPT Codes - The mapping process revealed serious problems with the CPT-4 codes for psychiatry. Because psychiatry CPT codes are broadly defined, some codes include vignettes with a wide range of work values. For instance, the total work value for CPT-4 code 90847 (special family psychotherapy) was the average of two vignettes with work values of 186 and 322. APA Work Group members indicated that the vignettes assigned to some codes represented the low end of the range of cases that could be assigned to the codes. It was felt that the vignettes assigned to 90844 (medical psychotherapy) included cases at the low end of the code. This may account for the reduction in value assigned to psychotherapy under the RBRVS, because this is the most common code used by psychiatrists and an error in the work value can significantly skew results.

- Extrapolation to Non-Surveyed Services - In order to evaluate the results of the extrapolation, consultants to the APA created a family of "Medical Psychotherapy" that included four surveyed services. In order to test the validity of the methodology, the consultants attempted to determine whether or not the extrapolated values for the other surveyed services approximated the surveyed values. This was not the case, and some extrapolated values appeared to be unreasonable.

- Other Coding Issues - Over two years ago, APA established a Work Group on Codes and Reimbursement to address concerns about the inadequacies of the CPT for the wide range of psychiatric services and to prepare an idealized version of potential new codes. Members of this APA Coding Work Group and the RBRVS Work Group recently met together to address some minor modifications which could be made in CPT for psychiatry for the next edition to be published by the AMA. The AMA CPT Advisory Board has indicated a strong interest in addressing changes to psychiatric codes. In addition to problems with the breadth of psychiatric codes — in contrast to the current efforts to reduce codes — psychiatrists have reported ample evidence in certain areas of the country that there are many carriers unwilling to accept general medical codes from psychiatrists. While this is not a uniform experience, enough complaints have arisen to indicate that this is a widespread problem. APA will continue to work with our psychiatrists to assist in this area.

APA staff and psychiatrists also recently met with PPRC staff to discuss coding issues. PPRC staff were also receptive to our concerns.

Practice Costs

APA also noted concerns about the practice cost calculation. Practice costs are, in fact, lower for psychiatry as psychiatrists do not require the same equipment as many other specialties. They may be kept exceptionally low because of three factors: psychiatrists practice in a price-sensitive market resulting from limited insurance coverage of mental health services and high copayments and deductibles; practice costs can represent a consumption good; and many psychiatrists do their own billing and office accounting--costs of office practice not normally included in surveys.

QUALITY ASSURANCE AND PEER REVIEW

As the Committee addresses issues related to volume control, we wanted you to be aware of APA's own peer review and quality assurance program. For over ten years, APA has reviewed claims for the CHAMPUS program and for the past five years has reviewed claims from private insurers. Since 1979, the Peer Review and Quality Assurance Program has reviewed 1.5 million claims for the CHAMPUS program and conducted over 100 on-site CHAMPUS inspections. APA does not deny claims but works with the providers and institutions to assure appropriate provision of care. APA began its work in the peer review area analyzing inpatient cases retrospectively. In 1985, APA became involved with another private group in psychiatric preadmission review and psychiatric case management. The psychiatric case management program combines comprehensive services of preadmission certification and concurrent review of all types of institutional and outpatient care. Information about these programs was given to the Institute of Medicine as it plans its strategy for Peer Review and Quality Assurance under Medicare and was shared with the PPRC.

COMMENTS ON SELECTED RECOMMENDATIONS OF THE PPRC

APA compliments the PPRC and their staff on the extensive amount of work that has been done. Clearly, much thought and effort has gone into their testimony and draft report and the report also attempts to incorporate the important comments of the numerous affected parties. The PPRC's task has been and continues to be an enormous one. Even with the extensive time committment needed for their report to Congress, PPRC staff have evidenced a tremendous willingness to meet with the APA and expressed verbal support for many of our concerns.

These comments focus only on a limited set of issues. First, as indicated above, Harvard is planning to conduct an NIMH-funded refinement of their study for psychiatry. Because of the expected refinement, psychiatry feels strongly that our portion of an RVS should not be implemented until the further analysis has been completed. As noted in our testimony the vignettes chosen for psychiatry did not cover the full range of psychiatric care. Further, given the existing limitations and inadequacies of psychiatry codes under CPT-IV, the range of problems treated by psychiatrists cannot presently be appropriately coded. APA is working with both the AMA CPT Advisory Board and the PPRC staff to more fully address these issues and hopefully some coding modifications will be made in the near future. To use the current RBRVS results in Harvard's preliminary report to the NIMH would be clearly inappropriate.

Second, if CPT codes were totally accurate, specialty differentials, as noted in the PPRC draft report, would not be necessary. However, as previously stated and documented, these codes for psychiatry are not adequate. Therefore, the intensity of services provided by psychiatrists are not adequately defined and we feel that specialty differentials must be maintained.

Third, implementation of expenditure targets at this point in time would be premature. Without question, there is insufficient information concerning the impact these targets may have on beneficiaries and on service delivery. Unfortunately, and as the Committee and psychiatry know only too well, patients with mental disorders have, since the inception of the Medicare program, been subject to a patient-specific dollar limitation for the majority of their outpatient psychiatric care.

While not similar to a nationwide expenditure target, these patients are already placed at a financial disadvantage and are at continued risk for adequate access to care. Until a demonstration was conducted for national expenditure targets or more information was obtained on the potential impact of such a situation, we feel that our patients must not be placed at additional significant risk.

ADMINISTRATION BUDGETARY PROPOSALS

As you consider some of the administration budgetary proposals before you, we wish to make a special plea for patients with mental disorders. Some of the services provided to these patients are not primary care services. There should be increases for all services provided by our psychiatrists to patients with mental disorders.

We have shared with the Committee the complicated calculation for the Medicare outpatient psychiatric benefit. In addition, as is well-known nearly one quarter of psychiatrists' patients have no health insurance. A 1981 study showed that 40% of gross revenues to psychiatrists were on self-pay basis. The distribution of these payments between co-payments and total self-pay is unknown, but it appears that much of the Medicare "balance bill" is in fact a co-payment, because of limited psychiatric coverage and an effective 50% co-payment rate. In addition, because psychiatrists use a small number of codes in most states, and have done so since the 1970's the Medicare Economic Index may have kept the allowed amount artificially low. Therefore, further limitations may prove to be onerous ones.

Summary

APA supports the concept of an RVS based on resource costs, but feels that implementation of such an RVS for psychiatry must await the planned NIMH-funded refinement by Harvard. Some of the recommendations made by the PPRC may thus be premature (such as expenditure targets). APA's own experience with peer review and quality assurance demonstrates methods of providing cost effective care. We look forward to working with the Committee as these issues are developed further.

Chairman **Stark**. Mr. Levin.

Mr. **Levin**. Mr. Chairman, I don't have any questions. The hour is late, and we will be reviewing testimony further. It has been an illuminating hearing, Mr. Chairman.

Chairman **Stark**. Thank you. I just wanted to ask—Dr. Arens doesn't have anyone to refer his patients to. Dr. Bishop generally does not. Dr. Rogers, does the American College of Radiology have a position on our physician referral bill?

Dr. **Rogers**. Sir, our position on the H.R. 939, the Ethics in Patient Referral Act of 1989 is well known. We submitted for your hearing a written statement on March 2, 1989, and over the ensuing few weeks our position is unchanged in this matter.

We support the objectives of your bill.

Chairman **Stark**. Thank you. I guess your group here of hospital-based physicians, if with Dr. Sharfstein, being the odd person out here, from what I have heard today, you all are kind of in the middle. I would say the same thing about what other physicians are doing as far as the committee is concerned, and that is to stay in the arena until you can find a relative value scale that you all will sign onto. I don't think that Congress can do much to either hurry that along or slow it down with the admonition of what I am hearing from the administration on these across-the-board cuts. Quite frankly, what I heard indirectly from the administration is that they would have liked to have gotten on with the RVS fee schedule and a cap this year.

They are, I think, going to push in that direction. In the absence of being able to do that in a short period of time, I think the across-the-board cuts are just an attempt to save some money until there is a revision. I don't mind that to the extent that it might get you all back to the bargaining table.

The toughest thing about getting a bargain with one of these things is to have an iron stance, and you have got to sit tight until all of you agree on what the relative value scale is going to be. Once that is done, then our next battle is going to be how we come to some kind of gross cost containment, our side of the issue.

Again I don't think we have—we care except that it is obvious from the test today and the response of the members that there isn't much that we have to argue about or bargain with you except the dollars. We have heard the issues of rationing and we have heard the issues of all those things, but it just seems that that is something we are going to have to work out together.

I guess the only question I would ask you is are you comfortable with bargaining—if we are bargaining an overall cost containment, let's assume you have all been in the arena and you are going to sign on to a relative value scale. Then the next step is how do we save aggregate?

Are you content to bargain as a group, as a hospital-based physicians group as opposed to, say, primary care and insurance or, I guess, any other kind of fee? And before a group made up mostly of your peers or at least professionally trained people? Does anyone have a better discussion?

Dr. **Arens**. Well, we understand your problem, obviously. The whole issue of medical expenditure targets makes no sense to me unless you take it in one context, and the context is that you are trying to control volume procedures for all of medicine. And it is an all of medicine issue, and to separate out and say you are going to apply expenditure targets and put us into a group makes no sense.

Chairman **Stark**. It doesn't have to be totally volume, but it seems to me it has to be both.

Dr. **Arens**. Yes, it could be both. But outside of that arena I think each speciality can come up—we have been, for example, dealing with the inspector general on the issue of time, and I think we will be coming to you in the very near future with a proposal of how we can save you some significant money by changing the current system.

I don't think we are ready for expenditure targets because I don't think nationally we really have the answer. Do we want to do it by State? Certainly lumping specific specialties into expenditure targets is, to me, the worse of all of the three ways to deal with expenditure targets, and we would be opposed to that, being lumped for all intents and purposes at the present time with anyone unless it was all of medicine in the same group.

Chairman **Stark**. OK. Let me try a couple of other things for anesthesiologists. Do you see—does it make any sense to have copays for anesthesiologists?

Dr. **Arens**. Well, I would address this——

Chairman **Stark**. I mean as a way to hold down overutilization.

Dr. **Arens**. Copays? Not for anesthesiology alone.

Chairman **Stark**. Do you have a high degree of uncompensated care in general?

Dr. **Arens**. Well, in general, myself specifically, being from a University of Texas school, with our economy down there, the answer is, yes. I would warn you, however, one thing when you are thinking of mandatory assignments——

Chairman **Stark**. No, you didn't hear that from me.

Dr. **Arens**. When our colleagues talk about that, you need to look at private sectors.

Chairman **Stark**. I am trying to think about how I can voluntarily get you in there. I am thinking of you up front. I think I can find a way if you and I want to sit down long enough that I can encourage you.

I have the old horse to water theory. There is no sense making mandatory assignment or there will be the chance that an occasional practitioner will just steer patients away, and I don't want that. I want you to be happy in you work, especially if you are working on me.

Dr. **Arens**. The other thing that makes no sense to us, is equating emergency situation with mandatory assignment because—not for the emergency physician, but we take our surgical colleagues and us—any time you take a procedure and take it out of elective and change it to the emergency, the risk changes dramatically. And so in that situation that is just the wrong place to do it because for us, the degree of difficulty in patient outcome is significantly affected just by that fact——

Chairman **Stark**. The only time I think about when we should pay you on a time basis is moving adhesive tape. I am one of those guys who believes the only medical procedure I have ever gone through ought to be done very quickly. Well, I appreciate all of you being here today. One other question.

For those of you who have a large amount of your patients under Medicare, and one or two of you testified—who testified about liability costs? No one? No one in this group? OK.

Then you are all happy with malpractice.

Dr. **Arens**. No, we are not happy about malpractice, but I think we support strongly the PhysPRC's recommendation about splitting out malpractice as a separate cost item.

Chairman **Stark**. How do you like the idea of saying that if you are a Medicare beneficiary you can't sue for malpractice unless you go through some kind of a review commission as we do on workmen's compensation?

Dr. **Arens**. I think some sort of proposal like that makes sense.

Chairman **Stark**. Would we get any support out of your profession for something along those lines—a no-fault procedure for all Medicare beneficiaries?

Dr. **Rogers**. We would certainly like that.

Chairman **Stark**. We are paying for it anyway. I think the only people who would oppose it would be the trial attorneys, and they are not here today.

Dr. **Arens**. I think Congressman Donnelly's assumption that the risk for malpractice cases is different than for the rest of the population, I think, is in error if you split out obstetrical cases.

Chairman **Stark**. Well, gentlemen, I look forward to working with you as we try and solve this. Thanks very much for your patience.

[Whereupon, at 4:45 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

[Submissions for the record follow:]

STATEMENT
OF THE
AMERICAN ACADEMY OF NEUROLOGY
TO THE
WAYS AND MEANS SUBCOMMITTEE ON HEALTH
ON
RECOMMENDATIONS OF THE
PHYSICIAN PAYMENT REVIEW COMMISSION

The American Academy of Neurology (AAN) appreciates this opportunity to express the views of neurologists nationwide on reform of the system Medicare uses to pay for physician services, and particularly to respond to the proposals recently released by the Physician Payment Review Commission (PPRC).

The Academy is a national association representing over 10,000 neurologists and neuroscientists. We have been involved in the Commission's efforts to reform physician payment under the Medicare payment system since the inception of PPRC. We would like to take this opportunity to inform this Committee of our views and concerns regarding the establishment of a fee schedule based on a resource based relative value scale, and other issues the committee will be addressing as a result of the PPRC's recommendations in its annual report.

Implementation of a Payment Schedule

The Academy, through its representatives on one of Harvard's Technical Consulting Groups, has been an active participant in the Harvard Resource-Based Relative Value Scale (RBRVS) project.

We certainly share the enthusiasm and belief that the RBRVS will be positive for medicine and medicare beneficiaries in its overall impact in re-aligning the incentives for the provision of care. Moreover, we believe that the RBRVS study is a major step forward in reforming the way physicians are reimbursed under Medicare.

The Academy recognizes that there are limitations to the Harvard RBRVS study, and believes that it needs to be sufficiently refined, corrected and expanded to be an acceptable basis for reform. We are aware of the work the PPRC is doing to help improve, and refine some of the inadequacies of the Harvard study. Such efforts, along with improvements the researchers are making in the second phase of the study, particularly the inclusion of neurology and other specialties in the second phase, will produce a more satisfactory basis for a resource-based payment schedule. At that time we believe we will be in a position to endorse, unreservedly a payment schedule based on the RBRVS study.

One aspect in particular of the Harvard study that the Academy would like to see more fully addressed is the absence of mechanisms to recognize and measure the complexity of cases treated by specialists such as neurologists. Other concerns, including the treatment of practice costs; estimations of pre-and post-service work; the measurement of resource costs for evaluation and management services; and the identification and measurement of case mix are all issues that neurologists would also like to see evaluated more carefully.

ISSUES ASSOCIATED WITH A PAYMENT SCHEDULE

Coding Reform of Evaluation and Management Services

The Academy is particularly concerned with issues relating to the reform of coding for evaluation and management services such as visits and consultations. This is the subject of significant interest to neurologists because such codes are mainly used to identify the care we provide to our patients.

The AAN supports the PPRC's study of physician coding and its analysis that a coding system should provide data that more accurately represents medical services provided to a patient. The Academy also agrees with PPRC's analysis that the coding requirements of a resource-based fee schedule are unique in that a coding system must take into account time, effort, and intensity expended by a physician in performing a medical service. The Commission found that CPT visit codes do not uniformly represent the amount of time and work expended in performing a medical service. We agree that there is variation in how neurologists and other physicians use and interpret CPT codes for the services they provide.

The Mendenhall study, referred to in the Commission's report as the USC study, found, among other things, that neurologists have the longest patient encounter time of any of the medical specialties involved in ambulatory care. Therefore, the study directly relates to the difficult and complex nature of a neurological examination and the need to have appropriate coding to recognize the time and effort expended to complete such an examination. The AAN supports a method of coding that would incorporate time in the definition of levels of service and would lead to the development of more accurate values for evaluation and management (EM) services based on the estimated relationship between work and time. This method would also be compatible with the current coding system.

We are concerned, however, that the Commission is too heavily dependent on time as the major factor in describing the levels of evaluation and management services. The Academy believes that factors other than time (such as more highly defined components of physician work, complexity of care provided and severity of illness) are extremely important to be included in the coding system. However, any changes in the coding system should ultimately reflect the actual services rendered to the patient -- and should not simply be a function of time and effort. Time is an extremely important factor, but the Academy envisions a coding system that incorporates a description of specific services as well as time in the definitions for evaluation and management services. These definitions would help ensure equitable payment for more efficient physicians and will facilitate carrier verification. Although the Commission has also stated this, we are concerned that this point is not made as clearly as it should be or with enough emphasis. We hope that when Congress implements payment reform, it keep in mind the need, down the road, to be able to incorporate these important factors in any payment system that is developed.

The Commission's second recommendation to Congress regarding evaluation and management services -- to delay the legislative mandate to group codes for payment purposes until reform of coding for evaluation and management services is completed -- is a good one. The Academy supports it fully. It is in keeping with our belief that until the coding system has been revised to reflect accurately the services provided and the resource costs expended, no interim changes to the system should be made. The Academy believe~~s that~~ such changes may serve only to hamper efforts underway to move toward a more rational system of defining and paying for physician services.

Specialty Differentials/Amortized Cost of Specialty Training:

Another area of specific concern to the Academy is the action the Commission has taken with respect to the different resource costs expended by various specialties. The Commission makes the recommendation that specialty differentials should not be incorporated into the Medicare fee schedule. Although the Commission is correct in stating that if the coding system were revised appropriately, there may not be any need for differentials, the AAN does not believe that the Commission has adequately shown that what is planned in the way of coding changes will in fact identify differences among physicians in the resource costs required to provide the evaluation and management services typical for their specialty. Without certainty that coding will improve, nor without any assurances that complexity of care and severity of illness modifiers will be reflected in the changes, the Commission is making a premature assumption when it specifically opposes specialty differentials. We believe that this recommendation is premature and Congress should not act to implement such a provision in the fee schedule until such time as revised CPT codes for evaluation and management services have been developed.

Attendant to the above consideration, AAN is also concerned that the Commission has dropped the specialty training cost factor (AST) from the equation for the RVS. The reasoning behind the Commission's approach also seems premature. The PPRC has stated that it believes that physicians should be paid the same when the service is the same. The Academy believes that until the Commission can show that complexity of care and severity of patient illness are included in the coding system, we cannot know that the service is the same. In fact, the Academy, in its previous testimony presented to the PPRC, has emphasized the uniqueness of a neurological examination. To perform such an examination requires special training and expertise in neuroanatomy, neurophysiology, and the subsequent formulation of an appropriate diagnosis with a plan for therapy. The examination is complex, and understanding the results of the examination requires special training not usually acquired in medical school.

The procedure code for a neurological examination should be a modifier of the basic procedure because it is a completely different procedure and not a standard examination. This would be applicable to consultation, at various levels, initial and/or hospital visit. The basis for this statement derives from the Mendenhall of "USC" study performed in 1977.

The log-diary survey currently underway will help provide data as to the different case mix and resource costs provided by at least some different specialties. We believe the Commission is prematurely assuming that these differences will be addressed. If neither specialty differentials nor specialty training costs are reflected in the RBRVS the Commission, and Congress, if it adopts these recommendations, is asking physicians such as neurologists to accept, on faith, that a future coding system will address these differences.

Expenditure Targets/Practice Guidelines:

AAN is concerned that the Commission again has acted prematurely in calling for expenditure targets after the first year of a RBRVS fee schedule. The AAN shares Congress' concern to moderate the rate of growth of Medicare expenditures. The difficult question is how to limit growth without threatening the quality of care or moving towards a system of "rationing" care. The quality of patient care and the access to care must not be jeopardized under any kind of Congressional budget-cutting plan. The Academy opposes expenditure targets as an inappropriate method to reduce Medicare expenditure growth.

The Academy supports continued studies and efforts to develop outcome assessment and practice guidelines. Until practice parameters and outcome assessment research can tell us what is appropriate care, expenditure targets will serve no policy purpose in reducing outlays.

The Academy has begun a quality standards program and there is strong organizational commitment to setting guidelines for neurologic care. The Academy feels it is imperative that neurologists participate in the development of practice guidelines for neurology.

Mandatory Assignment:

The Academy is pleased to see the Commission recommend against mandatory assignment. The Academy believes that a payment schedule based on a RBRVS should not be linked to mandatory assignment. We believe that low-income beneficiaries should be protected from charges they cannot afford, but the voluntary assignment option should be maintained.

The Academy supports appropriate limits on balance billing to low-income beneficiaries. The PPRC's proposal to require acceptance of assignment for all individuals whose costs are shared by state Medicaid programs is consistent with this principle. The Academy is concerned about access for patients needing neurological care, and has established an Access to Neuro-Care Task Force. This Task Force is exploring steps neurologists can take to assure that indigent patients have access to high quality neurologic care.

Since the data show that doctors generally consider individual patients' financial needs when determining their fees, the Academy believes that mandatory assignment is unnecessary. In addition, we believe there are other more positive ways to increase assignment than by mandating it. The current high assignment rate of charges (78.7%) could be even higher if the government would correct substantial problems with Medicare. If Medicare would increase its reimbursement levels, particularly for evaluation and management services, physicians would, we believe, be more likely to accept assignment for that service.

The Commission's draft paper on "PPRC Beneficiary Survey" indicates a larger problem with respect to assignment policy that needs to be addressed. A majority of Medicare beneficiaries do not know their options and rights under the Medicare program. They do not know what Medicare should pay for, what they must cover out-of-pocket according to law, or even that they can ask their doctor not to charge more than the Medicare allowed charge.

All of this data speaks to the need for better education of beneficiaries as to their options and rights under the Medicare program. Physicians are clearly responsive to the financial and health concerns of their patients, but more needs to be done. The Academy strongly believes that mandatory assignment is not the answer, but that much can be done to help close the gaps for the small percentage of poorer and sicker patients rather than mandating across-the-board assignment. The ability of patients and physicians to contract for services at a price that varies from the Medicare allowed charge must be preserved under a RBRVS payment schedule.

Under a schedule of allowances beneficiaries will be able to predict in advance how much Medicare will pay for a given service. They will then be able to compare that allowance with the physicians' actual charges to predict more effectively their out-of-pocket liability for the services. Consequently, the Academy believes that patients should have the freedom to choose a personal physician they think offers a higher level of skill or experience and who may appropriately charge more.

Conclusion

In conclusion, the AAN urges Congress to establish policies that will (1) provide a scientific basis for controlling the volume of inappropriate services; (2) protect low-income beneficiaries from charges they cannot afford, while maintaining the availability of the individual assignment option; and (3) establish a payment schedule that recognizes through coding or some other fashion, the additional resource costs expended by neurologist's and other specialists in providing care to their patients.

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STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

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Access to Obstetric Care

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The American College of Obstetricians and Gynecologists (ACOG), an organization that represents more than 28,000 physicians specializing in the delivery of health care to women, has supported, and continues to support the development of rational systems of reimbursement in both private and public health care delivery systems. The major concern in analyzing proposed changes in reimbursement methodologies must be the impact such changes would have on access to health care for all American women. An area of particular concern is maternity services, including prenatal care, labor and delivery services and postpartum care. With the current liability climate, more and more obstetricians-gynecologists and family physicians are giving up the practice of obstetrics. This creates acute problems for women in rural or other areas that may already be underserved and for this nation's poor. Against this backdrop, we must be extremely careful that any changes we make in reimbursement systems do not cause more physicians to give up the practice of obstetrics for when they do, the women who need their services suffer.

Although it may be suggested that obstetrics is not a significant portion of the Medicare budget and therefore not worth a special focus, we must disagree for two reasons. First, if a RBRVS is developed, refined, and implemented for the Medicare program, third party payors may adopt it as well. Thus, the 3.7 million women who have babies each year are potentially affected by any action taken by the federal government with respect to a RBRVS. One only has to look back to the recent adoption of the Medicare prospective payment system for hospitals by Champus for an example. This Medicare system was quickly adopted for Champus services, including services to women of childbearing age and children, without adequate study and adjustment even though the Medicare system did not cover this population to any extent. Secondly, the 3000-4000 women per year who do have obstetric care provided by Medicare are particularly vulnerable to any decrease in the number of obstetric providers. To be eligible for Medicare, women of childbearing age must have a significant disability or end stage renal disease. These women are, with few exceptions, high-risk patients. Again, the liability situation has caused a drop in the number of obstetrician-gynecologists who treat high-risk women and additionally, caused a significant drop in the percentage of their practice that is devoted to high-risk patients. In 1985, less than 2% of our members devoted a nominal 10% or less of their practice to high-risk care. However, in 1987, 45% restricted their high-risk practice to such an extent. Reimbursement systems must not promote further declines in the willingness of physicians to provide high-risk obstetric care.

To determine the potential effect of implementation of the Harvard RBRVS, we compared reimbursement for obstetric care under Champus with the potential reimbursement based on the Harvard RBRVS for services included in maternity care, using the multiplier identified by the American Medical Association (.50). (We would have preferred to compare the proposed changes to current Medicare rates, but could not do so because the number of Medicare deliveries per year is not large enough for a statistical comparison.) This analysis suggests that for a normal, spontaneous, vaginal delivery the reduction in reimbursement would be 6.8%, and for a cesarean delivery, the reduction would be 29.3%. It would certainly appear that such marked reductions would constitute further disincentives to continue obstetrics or to limit practice to patients not presenting a high-risk pregnancy.

Also, it should be noted that this comparison used median Champus fees so that many obstetrician-gynecologists would suffer a far greater reduction. Again, it is important to note that the Medicare population is almost entirely at high risk when it comes to obstetric care.

ACOG would argue in favor of a series of global fees to reimburse direct physician services in obstetric care. We recommend several different global fees, based upon the nature of the risks involved in the pregnancy. For example, the fees for the care of a diabetic woman or a woman with end stage renal disease would include more visits of longer duration during prenatal care, more monitoring during labor, and probably more difficult delivery. Should such a series of global fees be utilized, we would recommend that they not be based primarily on whether the delivery is vaginal or cesarean as they are currently, but be dependent upon the complexity and additional time involved in the expected total care. In addition, physician fees for specialized diagnostic and therapeutic tests and procedures provided during pregnancy, labor and delivery beyond the standard ones need to remain separately billed items.

Such a reimbursement system would encourage, rather than discourage, the care of patients with high-risk pregnancies. When one combines the recent trend of fewer physiciang providing high-risk care with other societal trends, such as delayed childbearing, resulting in an increasing number of high-risk pregnancies, such incentives become especially important. Almost all of Medicare pregnancies are high-risk. Secondly, a disproportionately low delivery fee in comparison to that provided for prenatal visits might encourage an inappropriate increase in the number of prenatal visits, while discouraging needed labor and delivery services. It is our understanding that this may be occurring in some areas of Canada where physicians are reimbursed well for each individual prenatal visit and the reimbursement for labor and delivery is low. Anecdotal reports are that some physicians are scheduling a greater number of prenatal visits for each patient, with each visit being shorter in duration than seems to be appropriate. Individual physicians are said to be scheduling large numbers of patients in a short time period in order to compensate for the low reimbursement for delivery services. Patients whose conditions require higher levels of care because of complications are not being referred for such care. With a global fee there is no incentive for physicians to increase the number of prenatal visits beyond those indicated medically. Further, a global fee encourages women to go to the doctor as recommended since no additional costs are incurred for any additional visits.

Use of a global fee for reimbursement would require revisions of the CPT codes for obstetric procedures. Currently, there is one code for a global obstetric fee with no delineation by risk. Also, there is one code for labor and two for deliveries: one for vaginal delivery and the other for cesarean. Instead of these and the several codes for office visits, a coding system would be needed that would use risk factors in establishing codes. The codes would have to be clearly defined with what is included in each code understood by all. Many procedures associated with pregnancy depend on the patient and her physiologic response to her pregnancy. These procedures should not be included in the global fee, but reimbursed separately when indicated medically.

METHODOLOGY

Thus, ACOG believes that conceptually, a RBRVS could provide a rational reimbursement schedule and not impact negatively on access to health care. However, the Harvard RBRVS contains significant methodological problems that affect reimbursement for obstetric and gynecologic services and therefore, we do not believe it should form the basis for such a schedule. Our concerns with the methodology are outlined below.

Physicians Surveyed

Fewer obstetrician-gynecologists participated in the telephone survey than physicians of any other medical specialty included in this part of the project. Of 185 obstetrician-gynecologist interviewees, 89 were not eligible, not interviewed, or refused to participate. This represents a smaller number of interviews than for any other specialty surveyed. In addition, any interview response that fell further than three standard deviations from the mean was excluded from consideration because it was considered an outlier. Outlier status excluded 11 obstetrician-gynecologists, the largest number of any specialty surveyed. As a result of these exclusions, only 89 obstetrician-gynecologists, of whom only 70% were board-certified, supplied information upon which the investigators could draw their conclusion. In addition, there was no attempt to determine if the obstetrician-gynecologists interviewed currently practiced the particular procedures described in the vignettes and could therefore have up to date detailed knowledge of the content. For these reasons ACOG believes that the investigators should re-survey the specialty of obstetrics and gynecology to validate the data in the current study.

Calculation of the Time Component

The resources component "time" appears to have been given great weight in calculating total work effort. The study assumes that the relationship between time and total work is linear, that is to say, all time spent with patients is treated equally, regardless of the circumstances under which a physician's time is spent. ACOG disagrees. A RBRVS should recognize additional variations in the intensity of time. For example, stress in night call might be very different than that experienced in daytime call. Emergency visits versus scheduled time, phone consultations versus time spent in attendance with patients, travel time versus waiting time are all variations of time involving different levels of intensity of service.

In 1985, ACOG, utilizing a small-group consensus process, analyzed the time spent delivering services similar to those portrayed in the vignettes used by Harvard investigators. For many of the services contained in the Harvard study the ACOG estimate of time was considerably greater than that estimated by the Harvard investigators, for example, normal, uncomplicated labor in a multipara, labor in a moderately hypertensive patient, and uncomplicated ovarian cystectomy, laparoscopic tubal fulguration, and uncomplicated cesarean section for cephalopelvic disproportion. The differences noted in the Harvard study may be explained by the tendency of physicians to underestimate time spent in delivering a given service, a bias most likely to occur in a response requiring instant estimates under the time constraints of the type of telephone survey used in the Harvard study.

ACOG also questions the accuracy of the determination of pre- and post-procedure time. The Harvard investigators should be asked to validate the methodology use in calculating these measures of time in the second phase of their study. It was the sense of our technical consultants that pre- and post-procedure times can vary due to outside factors that are not accounted for in the current study.

Practice Costs

ACOG also questions the reliability of the data used in calculating total resources used in delivering a service. Costs such as rent, equipment, supplies, non-physician wages, fringe benefits, and professional liability were included. For each of the services surveyed, practice costs were estimated as a percentage of gross practice revenue. Cost and income data from 1983 were used in these calculations. Data from 1983 are six years old and cannot be used to project costs in future years.

The current costs of professional liability as it affects our specialty can in no way be reflected by 1983 data. We believe that a great deal of additional work needs to be done to reflect accurately professional liability costs. Insurers charge different rates based on geographic areas, services provided and area of specialty. The geographic areas need to be well defined and characterized according to the differential liability costs. Regional adjustments will not work. One sees this by comparing two states likely to be grouped together — Georgia and Florida. An obstetrician-gynecologists in Georgia may pay $60,000 for professional liability insurance while one in Florida may pay $93,000-$186,000. Also, many insurance companies charge very different premiums in different geographic areas in the same states. For example, one Florida company charges obstetrician-gynecologists in Dade and Broward $186,000 while those in the rest of the state are charged $93,000. Maryland rates vary from $48,000 to $65,000.

In many states a different premium is charged obstetrician-gynecologists if they do only gynecology. For example, in Alaska, one company charges an obstetrician-gynecologist who provides obstetric services $81,000 and one who provides only gynecologic services $43,000. In Colorado, the difference is from $62,000 to $29,000. In Florida, the obstetrician-gynecologist rate more than doubles if he or she provides obstetric services, going from $77,000 to $186,000.

Different specialities incur different liability costs. Although some companies in some states charge the same rates for family physicians doing obstetrics as for obstetrician-gynecologists doing obstetrics, many do not. For example, one Florida company charges family physicians doing obstetrics $77,000 and obstetrician-gynecologists $186,000. In Colorado, a family physician doing obstetrics may be charged $16,000 and an obstetrician-gynecologist $62,000.

Geographic cost variations for other resources involved in practice also need to be factored into any calculation of practice costs. For example, the mean professional expenses in the United States of self employed obstetrician-gynecologists in 1986 was $149,500, while the mean in the South Atlantic region was $180,100. Costs even vary with the obstetrician-gynecologist's age; the mean being $124,100 for physicians aged 56-65 and $166,800 for physicians aged 36-45.

Unsurveyed Procedures

The researchers, in order to extrapolate from the procedures actually surveyed to other procedures within a given specialty, created small heterogenous "families" of services. These "families" were created by relating unsurveyed procedures to surveyed ones, based upon similar charges. ACOG has difficulty understanding how an extrapolation process that used charge data to group similar services would not transfer inherent flaws in the present charge-based system to the RBRVS. We believe that validation of this methodology is needed.

Severity of Illness

Some key components of resource costs appear to have been completely overlooked in the Harvard study. For example, the only method used to account for severity of illness is that inherent within the CPT coding system. ACOG does not find this coding system adequate to account for differences in intensity and complexity of services delivered resulting from variation in the severity of illness. Also, differences in physician competence and expertise are not factored into the equation in any manner.

CPT Codes

The CPT coding system itself will require considerable revision before a RBRVS based upon it can be implemented as a method of physician reimbursement. The current CPT coding system is simply not precise enough, resulting in a given code being interpreted quite differently by different physicians. It is of interest to note that the investigators were unable to assign a CPT code for four of the service vignettes surveyed in the study.

CONCLUSION

In conclusion, our primary concern must be promotion of access to health care. This is particularly important for obstetric care. ACOG recommends that the Harvard RBRVS study be regarded as preliminary. Considerable work needs to be done to validate the methodology and results of the study, to further refine this approach by incorporating information and issues not considered in the initial work. Obstetric care is different from other medical services and these differences have not been adequately accounted for in the Harvard RBRVS. Failure to do so will result in impeding access to services which are essential to improving the health status to women and children.

STATEMENT
OF THE
AMERICAN COLLEGE OF RHEUMATOLOGY
TO THE
WAYS AND MEANS SUBCOMMITTEE ON HEALTH
ON
RECOMMENDATIONS OF THE
PHYSICIAN PAYMENT REVIEW COMMISSION

The American College of Rheumatology appreciates this opportunity to express the views of rheumatologists nationwide on reform of the Medicare physician payment system, and in particular, to respond to the proposals recently released by the Physician Payment Review Commission (PPRC).

The American College of Rheumatology is the only professional organization of physicians and scientists devoted to the study and treatment of rheumatic diseases and the education of professionals who care for these disorders. The vast majority of its 4500 members are rheumatologists.

A rheumatologist is a specialist who provides medical care to patients with arthritis, diseases of the immune system and other disorders that cause pain and inflammation of the joints, muscles, and bones. Osteoarthritis, rheumatoid arthritis, gout, systemic lupus erythematosus, bursitis, back pain, and osteoporosis represent some of the more than 100 types of rheumatic disease, which affect more than 37 million people in the United States and which are a leading cause of disability and absence from work in this country. By special training and expertise, rheumatologists are uniquely qualified among physician specialists to care for people with rheumatic diseases in a high quality and cost-effective manner, and to lead the team of health professionals who assist in treating these diseases.

The College has been involved in the Commission's efforts to reform physician payment under the Medicare payment system since the inception of PPRC. We have worked closely with Commission staff in addressing th issue for visit coding reform, and are participating in the log-diary survey. We would like to take this opportunity to inform this Committee of our views and concerns regarding the establishment of a fee schedule based on a resource based relative value scale and other issues the committee will be addressing as a result of the PPRC's recommendations in its annual report.

Implementation of a Payment Schedule

The American College of Rheumatology believes strongly that a resource-based relative value scale (RBRVS) should be the basis for the development of a Medicare physician payment schedule. The College recognizes that there are limitations to the Harvard RBRVS study, but believes that when it is sufficiently refined, corrected and expanded, it will be an acceptable basis for reform. We are aware of the work the PPRC is doing to help improve and refine some of the shortcomings of the Harvard study. Such efforts, along with improvements the researchers are making in the second phase of the study, will produce a satisfactory basis for a resource-based payment schedule.

One aspect of the Harvard study that the ACR would like to see more fully addressed is the absence of mechanisms to recognize and measure the complexity of cases treated by subspecialists such as rheumatologists. Other concerns, including the treatment of practice costs; estimations of pre- and post-service work; the measurement of resource costs for evaluation and management services; and the identification and measurement of case mix are all issues that rheumatologists would also like to see evaluated more carefully.

Transition Period

The American College of Rheumatology believes that a transition period between the current Medicare system and any system involving a RBRVS payment schedule, while necessary, should be brief and determined by administrative considerations. A payment schedule based on the RBRVS should be implemented no later than January 1, 1991. In addition, the College believes that there should be periodic updates of the resource-based relative value scale, and any payment schedule based upon that RBRVS. Physicians must be appropriately represented and involved in this process.

ISSUES ASSOCIATED WITH A PAYMENT SCHEDULE

Coding Reform of Evaluation and Management Services

The College is particularly concerned with issues relating to the reform of coding for evaluation and management services such as visits and consultations. This is the subject of significant interest to rheumatologists because such codes are used virtually exclusively to identify the care we provide to our patients.

The College has been keenly interested in the Commission's work on this subject and has been actively working with the Commission in its efforts to examine the "visits" and levels of service issue. As one of the three specialties being evaluated as part of the log-diary survey, we anticipate that the results of the study will be extremely helpful in guiding the Commission toward decisions about coding refinements for evaluation and management services.

We are concerned, however, that the main emphasis of the Commission's recommendation and its report, is too heavily dependent on time as the major factor in describing physician work in the levels of evaluation and management services. The College believes that factors other than time (such as more highly defined components of physician work, complexity of care provided and severity of patient illness) are extremely important to be included in the coding system. Although the Commission has also stated this, we are concerned that this point is not made as clearly as it should be or with enough emphasis. We hope that when Congress implements payment reform, it keep in mind the need, down the road, to be able to incorporate these important factors in any payment system that is developed.

After reading the Commission's recommendations in the draft chapters of its 1989 report, The College is concerned that one might believe that incentives would be put into place to increase the volume of services. Physicians should not merely be able to have briefer and more frequent visits in order to increase their income. Such incentives seem distorted to the College. We believe that this emphasis is due to too much reliance by the Commission on a curvilinear relationship between work and time, "in which the overall amount of work per unit time is greater for shorter than for longer visits." Based on our members' knowledge of the services they provide, the College does not accept this relationship as a basis for coding--and subsequently payment--for evaluation and management services.

Rheumatologists are few in number. The data the Commission uses suggest to us that rheumatologists are probably outliers; patient encounters of rheumatologists do not fit that curve. The amount of work for the services we provide does not diminish with time. For example, due to the severity of illness of most of the patients we care for, the prevalence of a ten minute consultation is extremely rare. Such patient encounters are not within the norm of care provided by rheumatologists. We look to the results of the log-diary survey in which we are participating, to give us and the Commission a more factual basis upon which to rely--and to make judgments regarding the true components of physician work.

The College envisions a coding system that incorporates a description of specific services as well as time in the definitions for evaluation and management services. These definitions would help ensure equitable payment for more efficient physicians and will facilitate carrier verification. If CPT descriptors would continue to be refined to include elements describing the "content of services provided during the encounter, a more predictable and understandable coding system would be in place to address the complexity of care and/or severity of illness. Moreover, if done properly, it would allow both physicians and carriers to have a system capable of being verified.

This is particularly important for rheumatologists and their patients; in most parts of the country there is a lack of recognition by many Medicare and third-party carriers of rheumatologists as specialists separate and distinct from general internists. Many Medicare carriers do not recognize the rheumatologist as a specialist with unique training and expertise -- having an expected predominance of more severely ill patients leading to a more severe case mix and the need to provide more complex care. Rheumatologists are included under the more general designation of internists. This has a number of adverse ramifications for rheumatologists and their patients, not the least of which is the carriers' inability to distinguish appropriate care provided by a rheumatologist from that of a general internist. For example, screens used by carriers for such things as gold injections, laboratory monitoring of such injections, number of visits, and number of "higher level visits" frequently are denied and moreover, cause inequities in payment for rheumatologists and their patients.

The Commission's second recommendation to Congress regarding evaluation and management services -- to delay the legislative mandate to group codes for payment purposes until reform of coding for evaluation and management services is completed -- is a good one. The College supports it fully. It is in keeping with our belief that until the coding system has been revised to reflect accurately the services provided and the resource costs expended, no interim changes to the system should be made. The College believes that such changes may serve only to hamper efforts underway to move toward a more rational system of defining and paying for physician services.

Specialty Differentials/Amortized Cost of Specialty Training:

Another area of specific concern to the College is the action the Commission has taken with respect to the different resource costs expended by various specialties. The Commission makes the recommendation that specialty differentials should not be incorporated into the Medicare payment schedule. Although the Commission is correct in stating that *if* the coding system were revised appropriately, there may not be any need for differentials, the College does not believe that the Commission has adequately shown that what is planned in the way of coding changes will in fact identify differences among physicians in the resource costs required to provide the evaluation and management services typical of their specialty. Without certainty that coding will improve, nor without any assurances that complexity of care and severity of illness modifiers will be reflected in the changes, the Commission is making a premature assumption when it specifically opposes specialty differentials. We believe that this recommendation is premature and Congress should not act to implement such a provision in the fee schedule until such time as revised CPT codes for evaluation and management services have been developed.

Attendant to the above consideration, the College is also concerned that the Commission has dropped the specialty training cost factor (AST) from the equation for the RVS. The reasoning behind the Commission's approach also seems premature. The PPRC has stated that it believes that physicians should be paid the same when the service is the same. The College believes that until the Commission can show that complexity of care and severity of patient illness are included in the coding system, we cannot know that the service is the same. Patients for whom rheumatologists routinely provide care are more severely ill, and with more complex symptoms and comorbid illnesses than those of most other physicians who treat patients with rheumatic diseases.

The log-diary survey currently underway will help provide data as to the different case mix and resource costs provided by at least some different specialties. We believe the Commission is prematurely assuming that these differences will be addressed. If neither specialty differentials nor specialty training costs are reflected in the RBRVS the Commission, and Congress, if it adopts these recommendations, is asking specialists such as rheumatologists to accept, on faith, that a future coding system will address these differences.

Expenditure Targets/Practice Guidelines:

The College is concerned that the Commission again has acted prematurely in calling for expenditure targets after the first year of a RBRVS payment schedule. Much of the testimony the Commission received (and much of the testimony Congress has received to date) discussed the fact that an infrastructure through which physicians will be able to limit volume does not currently exist. In addition, the information that is needed to ensure that reductions in volume are reductions in inappropriate services, not necessary care, will not be available for three to ten years. Without such crucial information, including ongoing outcome assessment research and the development of practice guidelines, the Commission's recommendation amounts to rationing of care.

Any payment reform system should be developed, at a minimum in a budget-neutral fashion. The appropriate way to reduce Medicare expenditures is to reduce inappropriate care. This can be done through the development and implementation of practice guidelines and outcome assessment research.

The College is in full support of the development of practice guidelines and increased funding for outcome assessment research. We found the Commission's draft chapter, "Effectiveness, Research and Practice Guidelines," to be on target regarding these issues and particularly the need for increased funding of such efforts.

Mandatory Assignment:

The College is pleased to see the Commission recommend against mandatory assignment. We have testified to the PPRC on that issue to the same effect. The College believes that a payment schedule based on a RBRVS should not be linked to mandatory assignment. The College is opposed to mandatory assignment for several reasons, not the least of which is the lack of established need for it.

Since the data show that doctors generally consider individual patients' financial needs when determining their fees, the College believes that mandatory assignment is unnecessary. In addition, we believe there are other more positive ways to increase assignment than by mandating it. The current high assignment rate of charges (78.7%) could be even higher if the government would correct substantial problems with Medicare. We have stated to the Commission that we believe a payment schedule should be implemented at a minimum in a budget-neutral fashion. If Medicare would increase its reimbursement levels, particularly for evaluation and management services, physicians would, we believe, be more likely to accept assignment for that service.

Another reason physicians have been reluctant to accept assignment is because Medicare carriers frequently are not timely in processing claims. Lengthy delays in reimbursement can leave physicians, particularly those with high patient loads, with considerable overhead to cover. Even without balance-billing, a physician may wish to not accept assignment so that he can protect his cash flow and pay for his overhead.

The Commission's draft paper on "PPRC Beneficiary Survey" indicates a larger problem with respect to assignment policy that needs to be addressed. A majority of Medicare beneficiaries do not know their options and rights under the Medicare program. They do not know what Medicare should pay for, what they must cover out-of-pocket according to law, or even that they can ask their doctor not to charge more than the Medicare allowed charge.

All of this data speaks to the need for better education of beneficiaries as to their options and rights under the Medicare program. Physicians are clearly responsive to the financial and health concerns of their patients but more needs to be done. The College strongly believes that mandatory assignment is not the answer, but that much can be done to help close the gaps for the small percentage of poorer and sicker patients rather than mandating across-the-board assignment. The ability of patients and physicians to contract for services at a price that varies from the Medicare allowed charge must be preserved under a RBRVS payment schedule.

Under a schedule of allowances beneficiaries will be able to predict in advance how much Medicare will pay for a given service. They will then be able to compare that allowance with the physicians' actual charges to predict more effectively their out-of-pocket liability for the services. Consequently, the

College continues to believe that patients should have the freedom to choose a personal physician they think offers a higher level of skill or experience and who may appropriately charge more.

Conclusion

In conclusion, the American College of Rheumatology urges Congress to establish policies that will (1) mandate a payment schedule based on the RBRVS for implementation no later than January 1, 1991; (2) provide a scientific basis for controlling the volume of inappropriate services; (3) protect low-income beneficiaries from charges they cannot afford, while maintaining the availability of the individual assignment option; and (4) establish a payment schedule that recognizes through coding or some other fashion the additional resource costs expended by rheumatologists, and other specialists in providing care to their patients.

MASI-0065

STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists appreciates the opportunity to comment on the 1989 recommendations of the Physician Payment Review Commission and on the budget proposal to eliminate an increase in the Medicare Economic Index (MEI) update for non-primary care services in fiscal year 1990. The College represents more than 10,500 physicians who are board-certified in pathology. Our members provide patient care services in hospitals and independent laboratories.

Physician Payment Review Commission (PPRC) Recommendations

The College commends the Commission on its work and supports some of the proposals made by the Commission. Other recommendations are premature or unwise in our view. We strongly advise against adopting all of the PPRC recommendations. We submit the following specific comments on the 1989 recommendations of the Commission:

1. **The College strongly advises against including pathology services in RBRVS implementation until the Hsiao restudy of our services is completed and the RBRVs have been subjected to the same rigorous review that has been applied to the RBRVS developed in the first phase of the study.**

   The College of American Pathologists has communicated to the Physician Payment Review Commission on several occasions the need for a restudy of the resource-based relative values (RBRVs) of pathology services. We have met with William Hsiao, PhD, and are continuing discussions with him regarding parameters of a restudy. These discussions have been productive. The College Board of Governors has approved funding of the restudy based on a preliminary cost estimate provided by Dr. Hsiao. In his communications to us and to the Congress Dr. Hsiao indicates that he is confident that a mutually satisfactory agreement for restudy can be reached. We share that confidence.

   Use of the current RBRVS for pathology services is clearly inappropriate given the many problems with data collection and cross-linkage for pathology that we have identified. Dr. Hsiao has indicated that a pathology restudy could be completed by the end of 1990. It is inequitable to implement a pathology RBRVS in advance of completion and review of the restudy.

   In addition, a report on a relative value scale fee schedule for pathology services is being prepared by the Secretary of the Department of Health and Human Services, as required by the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203). This report could provide useful information on the relative values of pathology services.

2. **We encourage the Subcommittee to reject the PPRC recommendation for a short (six month) RBRVS start-up period regardless of when authorizing legislation is enacted.**

   We oppose implementation of a pathology RBRVS on April 1, 1990, and until the Hsiao restudy of pathology services is completed and has been subjected to rigorous review.

   The Commission recommends enactment of legislation this year to establish a Medicare fee schedule based on RBRVs with implementation six months after enactment and a two-year transition period.

   We believe there are ample examples in Medicare program history to support a conclusion that implementation of an RBRVS fee schedule will be characterized by disruption and confusion among physicians, Medicare carriers, and Medicare beneficiaries. Implementation of such a revolutionary change without adequate preparation by the Health Care Financing

Administration and carriers and with inadequate attention to communication to physicians and beneficiaries will only worsen the disruption that the change will produce.

We do not believe that a six-month period from authorizing legislation to implementation date is adequate for preparation and communication about the change. For example, if the Medicare Participation program is to continue then equity would require that physicians be given an opportunity to sign or rescind participation agreements based on knowledge of new fee schedule amounts. We do not believe that Medicare carriers would be able to establish the new payment methodology and provide physicians with the information necessary to a participation decision within six months of enactment of legislation.

3. **We support and appreciate the decision of the Commission not to recommend mandatory assignment**. We believe that Commission staff analysis of current balance billing characteristics demonstrates that balance billing amounts are not a problem for pathology services. Likewise mandatory assignment for pathology services would do little to reduce the out-of-pocket medical expenses that beneficiaries incur.

   It has been suggested that balance billing is inappropriate in the context of a Medicare fee schedule that seeks to rationalize payment among services and physicians. We believe that it is inappropriate to mandate assignment in the context of a new payment methodology, untested and as yet incomplete, that will likely require refinement and adjustment.

4. **We support the Commission statement that a national fee schedule requires that codes for physician services be interpreted uniformly** by all physicians and carriers. We believe that physicians who provide the services described by the codes should determine how services are coded and be involved in any effort to define coding policy. RBRVs for pathology services should not be implemented until ambiguities in coding interpretation and use of surgical pathology codes have been resolved.

5. **The College supports the development of clinically relevant practice guidelines** that respond to questions of utilization of laboratory tests. We believe that physicians knowledgeable in applications and limitations of laboratory testing are the appropriate source of such guidelines. Federal funding for private sector physician-development of practice guidelines could produce clinically sound guidance that physicians can integrate into their practices.

   Toward that goal, the College sponsored a Consensus Conference on Appropriate Laboratory Testing Guidelines in March 1989. Representatives of medical specialties, the Blue Cross/Blue Shield Association, government agencies, industry and labor participated in what we believe was a productive first step in development of appropriate laboratory testing parameters.

6. **The College opposes expenditure targets for physician services**. The Commission recommends a national expenditure target under Part B to be used to determine annual conversion factor updates under the fee schedule. The target would reflect, in part, a decision concerning the appropriate rate of increase in volume of services per enrollee that would reflect tradeoffs between beneficiary needs, technological advances, and affordability.

The College believes that physicians must share the responsibilities of balancing escalating costs, responding to questions of utilization, and assuring access to needed health care services. Practice guidelines, appropriately developed and applied, hold promise for ensuring that needed care is provided and unnecessary services curtailed. The Commission also recommends other policies intended to reimburse physicians and beneficiaries appropriately for needed services, such as realignment of relative values of payment levels, new definitions of some service codes and service groupings, and development of practice cost and geographic variation factors.

To impose upon this network of new payment methodologies a rationing mechanism such as expenditure targets is a radical departure from the Medicare program commitment to provide beneficiaries with (covered) medically reasonable and necessary services. When implemented in the context of Medicare policy intended to identify and pay for needed services only, an expenditure target would implicitly sanction withholding of payment for services that are needed. The obvious product of an expenditure target would be an incentive to ration needed services.

We encourage the Subcommittee not to adopt the PPRC recommendation for use of expenditure targets.

Fiscal Year 1990 Freeze Proposals

The College opposes elimination of the MEI update for nonprimary care services.

The Administration proposes that nonprimary care services receive no prevailing charge update in 1990. Nonprimary care services are defined as services other than physician visits provided in an office, nursing home, home, or emergency department setting.

The Medicare Economic Index is an inflation index used to limit updates in prevailing charges to increases in overhead and general wage levels. Nonprimary care services are affected by inflation in overhead and other costs just as are primary care services. There is no credible evidence that pathology physician services are overpriced. We believe it is inequitable to forego the scheduled MEI update for pathology services.

The College would also oppose any proposal to freeze clinical diagnostic laboratory services in 1990. Payment for these services has been the subject of numerous reductions and limitations in recent years. In 1984 Congress radically changed the payment methodology for Medicare clinical diagnostic laboratory services. In every budget reconciliation act since 1984 the Medicare fee schedule for these services has been subjected to additional restrictions, reductions, rebasing, or ceilings. Further restrictions could seriously compromise the quality of clinical diagnostic laboratory services.

Conclusion

The College of American Pathologists urges caution in early implementation of a RBRVS. In particular, pathology services should not be included in an RBRVS until the Hsiao restudy of pathology is completed and subjected to the same rigorous review that has been applied to other parts of his work.

We oppose freezing of pathology physician services and clinical diagnostic laboratory services in 1990. These services are subject to the same inflation as other services and should receive their scheduled updates.

Thank you for the opportunity to comment on PPRC 1989 recommendations and Administration budget proposals for 1990.

THE FOLLOWING STATEMENTS ARE SUBMITTED BY:

STEVEN J. THORSON, M.D.
PRESIDENT, LARIMER COUNTY MEDICAL SOCIETY

JAMES C. DANFORTH, M.D.
PRESIDENT-ELECT, LARIMER COUNTY MEDICAL SOCIETY

REPRESENTING THE MEMBERSHIP OF THE LARIMER COUNTY MEDICAL SOCIETY

At a time when there seems to be no limit to what science and technology can accomplish, this country is beginning to discover its own limitations. America is discovering it can't "afford" to be all things to its citizens let along the world. When Medicare was first legislated in the mid-1960's (despite extreme scepticism of organized medicine) the world indeed was a "kinder and gentler" and less complicated place. Not withstanding that, the creators of Medicare knew it had to be limited to some extent.

The following quotes come directly from an early Medicare beneficiary handbook: "Medicare will help pay for many of your health expenses, but not all of them. Medicare does not pay the full cost of some covered services. The amounts Medicare does not pay are described in this handbook. As general health care costs rise, these amounts may increase. If your doctor's or supplier's charge is higher than the reasonable charge, this does not necessarily mean that his or her charges are unreasonable."

Our current legislators 20 years later find themselves the guardians of a dinosaur that, rather than becoming extinct, has changed into an octopus with giant tentacles that threatens to strangle the national budget and drown health care providers and Medicare beneficiaries in a sea of ambiguous regulation. With the "aging" of America and the explosion of medical technology, both the demand for and the cost of health care have accelerated with each year.

To even suggest the obvious, i.e., that there are insufficient funds available to the U.S. government to pay for all the services that have been promised to senior citizens would surely be political suicide. Instead, Congress has abdicated its responsibility and created a bureaucratic "fall guy" called Health Care Financing Administration (HCFA).

Rather than face the unspeakable truth, HCFA has been given license to rain a cloud of inefficient, arbitrary, confusing regulations on health care while freezing or reducing reimbursement. This sorry stop-gap measure has only bewildered beneficiaries and alienated providers which is beginning to threaten access to care for seniors.

There is an old adage in medicine that says: "When the diagnosis is in doubt, examine the patient!" As practicing physicians, the guys and gals who actually take care of the Medicare patients, we propose that an analogous examination of Medicare be undertaken by Congress. We'd like to offer our perspective of the problems and to suggest workable solutions to those problems:

PROBLEM: MULTIPLE & FREQUENT REGULATION CHANGES

Over the last few years, physicians have been subjected to an incredible, and seemingly unceasing, series of regulatory changes relating to Medicare. Virtually none of us are able to begin to assimilate and understand, much less comply with, this barrage of bureaucratic "red tape," Congress and its HCFA functionaries seem to have complete disregard for the need for physicians to expand their mental energy, as well as their professional time, **TAKING CARE OF PATIENTS**, rather than trying to wade through the bureaucratic morass Medicare has become.

SOLUTIONS: INFREQUENT/FEW CHANGES ONCE IT IS "FIXED"

The current Medicare System desperately needs a thorough and complete "overhaul." The first step, albeit perhaps an unachievable objective, would be a complete and total restructuring of the Medicare System. Lacking that, however, let us agree to make only changes which are clearly necessary, to make changes no more frequently than annually, and to publicize such changes well in advance of effective dates in order to provide proper time for assimilation thereof.

PROBLEM: UNINTELLIGIBILITY OF CURRENT REGULATIONS

Physicians and patients are currently entrapped in an incredibly complex, often conflicting, and virtually incomprehensible network of Medicare rules and regulations. Those which are in written form are frequently unintelligible to the highly educated person, and are clearly well beyond the comprehension of the uneducated or mentally declining Medicare beneficiary.

SOLUTIONS: AVOID COMPLEX REGULATIONS; WRITE IN "PLAIN" ENGLISH

It is simply absurd to develop regulations which are so complex that essentially NO ONE can understand (a good example: MAAC regulations). The solution is to remove such existing regulations and create no new ones. We would suggest utilization of writers with excellent communication skills who would be required to prepare regulatory language intelligible to the average high school graduate. Should a regulation fail this test, it would be considered null and void.

PROBLEM: "CATCH-22" RULES AND REGULATIONS

For all practical purposes, it is IMPOSSIBLE to comply with certain Medicare rules. The most illustrative current example: A September '88 regulation was issued which requires physicians to tell their patient when and why a medical service will be determined to be "medically unnecessary," yet repeated informal, as well as formal, requests to HCFA for a comprehensive written summary of criteria used by the fiscal agents to make such determinations have been consistently refused by HCFA. Physicians CANNOT possibly comply with this rule without such criteria yet are subject to threat of monetary civil penalty for failure to do so.

SOLUTIONS: SUCH RULES & REGULATIONS ARE NULL & VOID

The obvious solution is to not pass regulations such as this in the first place. We would propose a comprehensive review of existing current Medicare rules and regulations by the General Accounting Office, with particular attention to the issue of whether the well meaning, honest physician can REASONABLY comply with them. Those which fail this evaluation should be declared null and void.

PROBLEM: LACK OF COMPREHENSIVE LISTING OF MEDICARE COVERAGES

There is no comprehensive and current listing of what medical services are covered by Medicare. Consequently, physicians, as well as their patients, often do not know what services will be covered.

SOLUTION: PREPARE A COVERED SERVICES GUIDE

Congress should require HCFA to prepare, and to revise annually, a written, detailed, comprehensive, and readable guide which itemizes which medical services are, or are not, covered by Medicare.

PROBLEM: "MEDICALLY UNNECESSARY" DETERMINATIONS BY CLERKS

Current regulations allow determinations of which services are "medically unnecessary" to be made by insurance clerks who have NEITHER professional medical knowledge or training NOR the involved patient's medical records (or summary thereof). Determination of whether a service is medically necessary can be properly made ONLY when the patient's specific medical condition is considered and ONLY when such judgment is made by a health professional with sufficient knowledge and/or training to be qualified to make the determination.

SOLUTIONS: "MEDICALLY UNNECESSARY" DETERMINATIONS BY PRO

All states already have professional review organizations in place and functioning (Colorado Foundation for Medical Care is an example) which could properly judge whether medical services are necessary. Such determination still would require proper patient specific medical information and properly trained health professional reviewers. If Congress wishes to require medical necessity judgements to be made by someone other than the patient's attending physician, and if it wishes to meet minimum standards of fairness and equitability relating to the Medicare beneficiary (not to mention the treating physician), it MUST meet these MINIMUM criteria.

PROBLEM: INADEQUATE PRACTICING PHYSICIAN INPUT

A vas majority of HCFA's decisions relating to medical care rendered to Medicare beneficiaries have little or no input from the perspective of the PRACTICING physician. These are the people who actually serve on the "front lines" and who provide direct patient care, yet they are afforded virtually no meaningful input regarding important decisions which affect not only their patients' medical well being but also their own professional lives.

SOLUTION: MANDATE MEANINGFUL PRACTICING PHYSICIAN INPUT

Congress should require HCFA to submit all proposed new Medicare rules and regulations to a physician panel, comprised of PRACTICING physicians who regularly treat Medicare patients, for review and comment. HCFA should be required to clearly demonstrate that it had given due consideration to the panel's comments and recommendations before final issuance of such rules and regulations.

PROBLEM: INEQUITY OF MEDICARE REIMBURSEMENT

The current Medicare policies allow for vastly differing reimbursement for identical medical services provided by different physicians. The discrepancy in reimbursement relating to geographical location is particularly egregious. It unfairly discriminates not only against the physician but also against the Medicare beneficiary (all of whom pay the same premium rates regardless of their domicile). Other discriminatory Medicare policies allow differing reimbursement for identical services provided by physicians of different specialties. One very obvious adverse effect has been the ever worsening shortage of physicians in rural areas.

SOLUTION: A NATIONWIDE EQUITABLE REIMBURSEMENT SCHEDULE

Congress should adopt a single, equitable, and uniform schedule of allowable reimbursement such that "equal pay for equal service" would be assured. The current "Resource Based Relative Value Study" (RBRVS) proposal, being considered by the Physician Payment Review Commission, if properly refined and perfected seems to represent the most likely mechanism to accomplish this objective.

PROBLEM: INADEQUACY OF REIMBURSEMENT

Current Medicare reimbursement levels are grossly inadequate and increasingly threaten to jeopardize Medicare patients' access to care. Physicians fees have effectively been frozen at 1984 levels while their costs have inexorably risen. As a result, many physicians find themselves providing service to Medicare recipients essentially "for free," (when one considers the "overhead costs" of practicing medicine).

SOLUTIONS: RBRVS, "BALANCE BILLING"

The RBRVS, if refined, perfected, and instituted, provides Congress the opportunity to establish Medicare reimbursement levels which realistically compensate the physician on a fair and equitable basis. Congress and the American People must stop trying to "balance the Medicare Budget on the backs of the doctors." We already pay our full share of taxes and Social Security contributions; it is clearly unfair to also ask us to subsidize the Medicare deficit as well. A substantial proportion of Medicare beneficiaries are wealthy. Others although not wealthy, are clearly able to pay fees equal to the difference between the physician's usual charge and the Medicare reimbursed amount. The "freeze" on physician fees is discriminatory and must therefore be discontinued. Physicians should be allowed to bill Medicare patients, for the difference between the usual fee and the Medicare reimbursement, based on the patient's financial "ability to pay" (see discussion of "means testing" below).

PROBLEM: MEDICARE SUBSIDIZES WEALTHY PEOPLE

Although most Medicare beneficiaries are people of insufficient, limited, or modest means, a significant number are very financially secure or wealthy. Our current system in effect pays a government subsidy to these individuals. This is bad public policy, especially when viewed in the context of the insufficient coverage for those who truly need help, and when viewed with regard to the discriminatory economic effects upon physicians, and hospitals.

SOLUTIONS: MEANS TESTING

We would propose a fundamental change in the Medicare eligibility and benefit structure: We would suggest that all Medicare beneficiaries receive full benefits until such time as they have recovered amounts equal to all of their contributions plus an amount representative of what investment earnings such contributions would have earned. Any subsequent benefits, however, would become equivalent to a welfare subsidy and thus appropriately would be determined subject to financial means testing. Poor and needy individuals would receive full benefits, while those of more substantial means would receive appropriately reduced benefits. Truly wealthy people would presumably receive no benefits. We further submit that most physicians, were such a system to be implemented, would be much more willing to "do their share" in providing for the needs of the poor.

PROBLEM: UNREASONABLE PUBLIC EXPECTATIONS

The fundamental basis for most, if not all, problems with the Medicare system is the underlying entitlement mentality of contemporary American Society. More and more people look to the government as the "pot of gold" at the end of the rainbow...a bounty in which they are "entitled" to share, regardless of their contributions or individual efforts, or individual need. As it relates specifically to health care, they want to continue to have the best medical care available, and they increasingly insist that it be perfect care each and every time, yet they feel entitled to have someone else pay the bill.

SOLUTIONS: LIMITS, FAIRNESS, AND PERSONAL RESPONSIBILITY

This IS the age of limits. We must as a society come to the realization that people cannot abdicate responsibility for themselves. We cannot continue to perpetuate unfair, inequitable, and discriminatory systems; most especially those perpetrated by our government. We as a society need to make the hard choices, for if we do not, our society will surely fail. As physicians we ask Congress to consider fundamental reforms in the Medicare System as one step in the right direction. We ask for courage, leadership, and reason.

TESTIMONY
OF
Peyton E. Weary, M.D.
on
Medicare Payment to Physicians
Submitted to
The Subcommittee on Health, Committee on
Ways and Means
U.S. House of Representatives

April 24, 1989

I am Peyton E. Weary, M.D., Professor and Chairman of the Department of Dermatology at the University of Virginia Health Sciences Center. The following testimony represents my personal observations and is not submitted on behalf of any organization or institution with which I am affiliated.

While physician payment reform is desirable to correct certain historical inequities in physician reimbursement under medicare, and while the resource based relative value scale (RBRVS) approach is a reasonable one there are certain aspects of the proposal submitted by the Physician Payment Review Commission (PPRC) which may have serious unwanted long term consequences and may create new inequities in the process of correcting existing inequities.

These are outlined below:

1. The lack of corrective factors for severity of illness or case mix.

In creating the prospective payment system for hospitals, the Congress acknowledged inequities in the severity of illness and case mix of teaching hospitals by providing an indirect medical education adjustment. Clearly the type of patients routinely seen in teaching hospitals on the average will have more severe illness and such accommodation is justified as a corrective factor.

These same inequities will apply to physicians who work in such settings or who have practices with a higher proportion of patients referred for more serious illness than the average. Unless there is some way to adjust for these inequities in case mix, physicians, or groups of physicians, who are seeing these more complicated cases, will be accorded inappropriately low levels of reimbursement for services while others will receive inappropriately high levels of reimbursement. To prevent such inequities it will be necessary to adjust payment levels to reflect severity of illness or case mix variations. The present proposal of the PPRC does not appear to acknowledge the need for such corrective factors, and before such reimbursement reforms are instituted, case mix adjustment strategies should be firmly in place.

2. Adjustments for Time Devoted to Teaching.

The concept of a resource based relative value scale is basically that of a proportionate reimbursement on the basis of time and effort. The teaching of medical students and residents takes time, particularly in an ambulatory or office - based setting where it may significantly increase the time the teaching physician spends with the patient. We are constantly being exhorted to increase the level of ambulatory care teaching for students, interns and resident physicians as a result of the shift away from in-hospital care to ambulatory care. At the present time one of the barriers to teaching of ambulatory care is the inadequate financial support for such teaching. With the advent of the RBRVS we will find yet another financial disincentive to teaching and this will have its most severe impact upon teaching in the ambulatory setting. Some serious consideration should be given to providing an adjustment for teaching physicians comparable to the indirect medical education adjustment provided under the hospital prospective payment plan.

3. Expenditure Targets

In the absence of clearly defined and appropriate standards, or guidelines of care, expenditure targets may serve more to punish the frugal physician who delivers appropriate levels of care and reward the physician who overutilizes services. Without standards of care in place in all disciplines, it will be difficult, if not impossible, to identify the consistent overutilizer. There is clear evidence that most specialties are moving rapidly to develop standards of care, but it will not be an easy task nor will it be accomplished quickly. For the above reasons expenditure targets are an ill-advised initiative.

4. Geographic Modifiers

In making geographic adjustments to the RBRVS the Physician Payment Review Commission utilizes only practice costs as the basis for such adjustments and does not adjust for geographic variations in the cost of living. This will possibly provide strong disincentives for younger physicians entering practice with significant educational indebtedness to set up practice in areas where the cost of living may be significantly higher. If the intent of this approach is to encourage physicians to populate non-metropolitan areas it may be partially successful, but an alternative outcome may be to encourage young physicians to enter more lucrative specialties, presumably an unwanted outcome. Furthermore, on a long term basis this could conceivably result in future shortage in the supply of physicians in the more expensive metropolitan areas. Clearly, this is an inequity which may have unwanted consequences at some future time. It would seem inappropriate to create a new problem in prescribing a long term solution.